

PATIENTS' RIGHTS

DISCLOSURE, CONSENT AND CAPACITY

NIKKI HEIDPRIEM
JUDITH RESNIK

THE recent Supreme Court decision invalidating state abortion statutes,¹ the much-publicized Michigan psychosurgery decision,² the growing number of right to treatment cases,³ and the issuance of federal guidelines protecting minors and other legally incompetent participants in federally funded sterilization programs⁴ have prompted a reconsideration of the personal rights of patients within the physician-patient-state relationship. Recent malpractice cases reveal an innovative trend in tort law expanding the physician's duty to disclose information to a patient in order to obtain that patient's informed consent.⁵ This article will discuss several of the complex issues associated with the physician-patient relationship: how courts define the physician's duty to disclose under the present law, when informed consent is required; when an adult is deemed incompetent by the state to give such consent, and what special considerations arise as incidents of minority.

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Ms. Nikki Heidepriem and Ms. Judith Resnik are staff members of the *Annual Survey of American Law*. Ms. Heidepriem wrote "Minors' Capacity to Consent to Health Care." Ms. Resnik wrote "The Physician's Duty to Disclose" and "The Elements of Consent: A Case Study—Mentally Ill Patients."

1. *Roe v. Wade*, 410 U.S. 113 (1973), and *Doe v. Bolton*, 410 U.S. 179 (1973).

2. *Kaimowitz v. Michigan Dep't of Mental Health*, Civil No. 73-19434-AW (Mich. Cir. Ct. July 10, 1973), noted at 42 U.S.L.W. 2063. See notes 105-54 *infra* and accompanying text.

3. See, e.g., *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971), appeal pending, No. 72-2634 (5th Cir. 1972), as discussed in *Civil Rights, 1972/73 Ann. Survey Am. L.* 339, 371-74.

4. See Dep't Health, Educ. & Welfare, "General Guidelines Limiting Federal Financial Assistance for Sterilization of Minors and Other Legally Incompetent Individuals," News Release, July 19, 1973. Formal regulations were issued September 21, 1973. 38 Fed. Reg. 26460 (Sept. 21, 1973). See *N.Y. Times*, Sept. 21, 1973, at 46, col. 3. Congress has also recently considered legislation to protect patients' rights. *N.Y. Times*, Sept. 17, 1973, at 34, col. 1, and Sept. 27, 1973, at 13, col. 1. See also draft of "Protection of Human Subjects: Policies and Procedures" 38 Fed. Reg. 31738 (Nov. 16, 1973).

5. See *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972), cert. denied, 409 U.S. 1064 (1972), analyzed in text accompanying notes 6-43 *infra*; *Wilkinson v. Vesey*, 110 R.I. —, 295 A.2d 676 (1972), analyzed in text accompanying notes 44-60 *infra*; and *Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972), analyzed in text accompanying notes 61-73 *infra*. See generally Note, *Informed Consent—A Proposed Standard for Medical Disclosure*, 48 N.Y.U.L. Rev. 548 (1973), for a cursory breakdown of the classic elements of this kind of tort action. *Id.* at 549. For an earlier discussion of this topic, see *Torts*, 1966 *Ann. Survey Am. L.* 209, 231-33.

I

THE PHYSICIAN'S DUTY TO DISCLOSE

In 1972, the United States Court of Appeals for the District of Columbia Circuit in its decision in *Canterbury v. Spence*⁶ forcefully asserted the rights of a patient to determine what should be done with his or her body.

Plaintiff Jerry Canterbury, a nineteen-year-old boy, had submitted to an operation performed by the defendant, a surgeon, without being told that there was a minimal risk of paralysis⁷ associated with the procedure.⁸ The plaintiff alleged that the defendant was negligent in his performance of the operation and in his failure to inform his patient of the risk involved. The doctor claimed that it was not good medical practice to communicate such risks because such knowledge might deter patients from undergoing needed surgery.⁹ Circuit Judge Spottswood Robinson III,

6. 464 F.2d 772 (D.C. Cir. 1972). The *Canterbury* interpretation of patients' rights may well conflict with the Supreme Court's most recently expressed views on the issue in *Roe v. Wade*, 410 U.S. 113 (1973), and *Doe v. Bolton*, 410 U.S. 179 (1973). In both *Roe* and *Doe* the Court concluded that the constitutionally protected right of privacy encompassed a woman's decision to terminate her pregnancy, but held that this right was nevertheless subject to the state's interest in safeguarding health. 410 U.S. at 154-63. Justice Blackmun relied upon two earlier Supreme Court decisions, one upholding the state's power to require vaccination, *Jacobson v. Massachusetts*, 197 U.S. 11 (1905), and another upholding the state's power to sterilize congenital mental defectives, *Buck v. Bell*, 274 U.S. 200 (1927), to determine that the Court did not recognize an "unlimited right" to do with one's body as one pleases. 410 U.S. at 154. The Court explicitly made the abortion decision a "medical" one, even during the first trimester, by placing responsibility with the physician:

This means, on the other hand, that, for the period of pregnancy prior to this "compelling" point, the attending *physician*, in consultation with his patient, is free to determine, without regulation by the State, that in his *medical* judgment the patient's pregnancy should be terminated. If that decision is reached, the judgment may be effectuated by an abortion free of interference by the State. 410 U.S. at 163 (emphasis added). See *id.* at 166. This concept is fundamentally contrary to *Canterbury*, which purposefully located final decision-making power in the patient. 464 F.2d at 780.

Similarly, in *Doe v. Bolton*, 410 U.S. 179 (1973), Justice Blackmun held that the hospital review committee, required by Georgia's abortion statute, was unconstitutional in that it invaded the doctor's right to administer medicine and the woman's right to receive care in accordance with her *physician's* best judgment. 410 U.S. at 197. Only Justice Douglas, in his concurring opinion in *Doe*, suggested that there was a strong constitutional basis for personal health rights in addition to their traditional common law foundations. *Id.* at 213. See also *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 105 N.E. 92 (1914), overruled on other grounds, *Bing v. Thunig*, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957).

7. The risk of paralysis inhered in the procedure (464 F.2d at 779) and therefore required a warning. The plaintiff's condition, however, may also have been caused by a trauma resulting from an accidental fall during the post-operative period. *Id.* at 778.

8. *Id.* at 777. In *Canterbury*, the risk was assessed at approximately "one percent." *Id.* at 778. It must be noted that the significance of any risk varies with the potential injury and the expected gain. Thus, the actual numeric figure attached to the risk is without independent meaning.

9. *Id.*

reversing the defendant's directed verdict and remanding the case for a new trial, held that the plaintiff had made a prima facie case of the physician's violation of his duty to disclose, and that it remained for a jury to decide whether such failure actually caused the plaintiff's injury.¹⁰

The court relied on what it deemed a "fundamental" principle of American jurisprudence that "every human being of adult years and sound mind has a right to determine what shall be done with his body. . . ."¹¹ In order to exercise the right to choose, the patient is dependent upon the physician to inform him or her of the benefits, risks¹² and alternatives available.¹³ Hence, the law requires "reasonable divulgence"¹⁴ by the physician as to each of these factors whenever a question arises as to whether a "particular treatment procedure"¹⁵ should be undertaken.¹⁶

The *Canterbury* decision is particularly significant because, in addition to recognizing the commonplace duty to disclose,¹⁷ it rejected outright the prevailing judicial practice of requiring expert medical testimony to define what constitutes acceptable physician-patient communication.¹⁸ The court concluded that no consensus existed on this issue within the medical profession,¹⁹ that each case presented such different circumstances

10. *Id.* at 779.

11. *Id.* at 780, quoting Cardozo, J., in *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914).

12. The duty to disclose encompasses potential or collateral dangers as well as inherent ones. 464 F.2d at 782.

13. *Id.* at 780, 782.

14. In distinguishing the "duty of disclosure" from the doctrine of "informed consent," the court noted that the focus in disclosure cases must be on the reasonableness of the extent of the physician's effort to communicate information, rather than on the patient's comprehension of the situation. *Id.* at 780 n.15. Furthermore, the physician's duty exists whether or not the patient has asked for any information. As the court phrased it, "[c]aveat emptor is not the norm for the consumer of medical services." *Id.* at 783 n.36.

15. The phrase "particular treatment procedure" includes but is not limited to surgery; the duty to disclose arises before commencement of any medical treatment, and implicitly extends to the risks of medications, physical therapies, and other non-surgical procedures. See *id.* at 781. The requirement thus goes beyond the procedures for which a physician normally obtains written consent. See, e.g., the consent forms presented in *Morris, Crawford, and Morritz, Doctor and Patient and the Law* 170-80 (5 ed. 1971). Accord, *Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972); *Wilkinson v. Vesey*, 110 R.I. ___, 295 A.2d 676 (1972).

16. 464 F.2d at 782.

17. See, e.g., *Dunham v. Wright*, 423 F.2d 940, 943-46 (3d Cir. 1970) (applying Pennsylvania law); *Campbell v. Oliva*, 424 F.2d 1244, 1250-51 (6th Cir. 1970) (applying Tennessee law).

18. 464 F.2d at 783. Compare *Haven v. Randolph*, 342 F. Supp. 538 (D.D.C. 1972), decided one day before *Canterbury* and requiring expert testimony on the disclosure issue. See *Natanson v. Kline*, 187 Kan. 186, 354 P.2d 670 (1960), discussed in text accompanying notes 74-78 *infra*. See also *Aiken v. Clary*, 396 S.W.2d 668 (Mo. 1965) (holding that expert testimony is required on this issue); *Washington Hosp. Center v. Batter*, 384 F.2d 331 (D.C. Cir. 1967); *Ze Barth v. Swedish Hosp. Medical Center*, 81 Wash. 2d 12, 499 P.2d 1, 52 A.L.R.3d 1067 (1972).

19. 464 F.2d at 783.

that a search for a general custom was inappropriate,²⁰ and that the rights of patients "demand[ed]" a standard set "by law for physicians rather than one which physicians may or may not impose upon themselves."²¹

Having rejected the general method of determining the scope of a doctor's duty to disclose,²² the court substituted its own test dictated by the "patient's need":²³ a physician must convey to a patient all material information the latter needs to make an "intelligent" decision (*i.e.*, the inherent and potential hazards of the treatment,²⁴ the alternatives to the treatment, and the results of non-treatment).²⁵ The court proposed that the jury consider whether all "material"²⁶ information had been conveyed and whether a reasonable person²⁷ would have been "likely to [have] attach[ed] significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy."²⁸

Canterbury also redefined the two long-standing exceptions to the rule of disclosure. The first exception was identified as the "emergency" situation which exists only when a person is unconscious or otherwise incapable of consenting to treatment,²⁹ when the failure to treat would result in imminent harm, and when the harm threatened outweighs any harm of the proposed treatment.³⁰ Before performing any procedure, the physician must attempt to secure the consent of a relative of the patient if possible.³¹ The court explained that while expert testimony of common

20. *Id.* at 784. The court did not preclude introduction of evidence of professional custom but explained that such testimony cannot "furnish the test for" the standard of care. *Id.* at 785.

21. *Id.* at 784.

22. See cases cited in note 18 *supra*.

23. *Id.* at 786. "[T]he patient's right of self-decision shapes the boundaries of the duty to reveal." *Id.*

24. *Id.* at 782. See note 8 *supra*. Statistically small risks would not automatically be excluded from disclosure. *Id.* at 788.

25. *Id.* at 787-88. Compare Note, Restructuring Informed Consent: Legal Therapy for the Doctor-Patient Relationship, 79 *Yale L.J.* 1533 (1970) [hereinafter cited as Restructuring Informed Consent], cited with approval, 464 F.2d at 783 n.36.

26. 464 F.2d at 786. The *Canterbury* court never formulated a precise definition of the word "material." The court noted that individual insignificant risks may achieve materiality in combination (*id.* at 788 n.89); nonetheless a physician need not communicate information of which an average person already would be aware or that would be of no "apparent materiality." *Id.* at 788.

27. Reasonable in "what the physician knows or should know to be the patient's position." *Id.* at 787.

28. *Id.* at 787, quoting Waltz & Scheuneman, *Informed Consent to Therapy*, 64 *Nw. U.L. Rev.* 628, 640 (1970).

29. 464 F.2d at 788. Interestingly, the court never defined the characteristics of "a patient incapable of giving consent." See *id.* at 782 n.32. See also notes 105 & 115-39 *infra* and accompanying text.

30. *Id.* at 788. It is unclear whether an "emergency" is limited to situations where a patient's life is endangered. Cf. the broader definition of "emergency" in N.Y. Pub. Health Law § 2504(3) (McKinney Supp. 1973).

31. 464 F.2d at 789.

medical practice is relevant, it is not controlling in proving the existence of such an emergency.³²

The second exception is the "therapeutic privilege," under which a physician may withhold information from any patient whom the doctor believes is so distraught that disclosure would be detrimental to his well-being.³³ After criticising the grant of such wide discretion,³⁴ the court carefully circumscribed this privilege by placing upon the defendant-physician the burden of proof that the privilege was properly exercised.³⁵ In assessing the propriety of the physician's use of the privilege, the physician's decision alone is insufficient legal support; rather, there must be independent evidence of the patient's emotionally unstable condition and of disclosure to one of his relatives.³⁶

Under *Canterbury*, the plaintiff has the burden of going forward with evidence as well as the burden of proof to show that the physician failed to disclose material information and thereby caused the plaintiff's injury.³⁷ The court explained that the requisite causal connection can exist only when the jury finds that a prudent person in circumstances similar to the plaintiff-patient³⁸ would have declined treatment had he known of the risks involved.³⁹ Each of these elements may be proved successfully without any expert testimony.⁴⁰ The court, however, did recognize a possible need to call expert witnesses to give opinions on technical medical questions or on the existence of an exception to the disclosure rule.⁴¹ Finally, the court protected the rights of patients by classifying the physician's omissions as negligence, rather than the intentional tort of battery,⁴² thereby giving the plaintiff the benefit of the longer statute of limitations.⁴³

32. *Id.*

33. *Id.*

34. *Id.* Many legal commentators share the court's disfavor. See, e.g., *Restructuring Informed Consent*, *supra* note 25, at 1533. For the moral and ethical arguments in favor of full disclosure from a physician's point of view, see J. Fletcher, *Morals and Medicine*, ch. 2 (1960).

35. 464 F.2d at 791.

36. See *id.* at 791, 794.

37. *Id.* at 791. However, the physician has the burden of going forward with evidence pertaining to the existence of a privilege. *Id.*

38. The court detailed the distinction between the "objective" test it had chosen and the alternative of a "subjective" test. *Id.* at 790-91. See W. Prosser, *The Law of Torts* § 32, at 149-50 (4th ed. 1971).

39. 464 F.2d at 791. Thus the testimony of the plaintiff is relevant but not dispositive of this causality element. The "materiality" of the information withheld will actually be the most crucial factor to a finding of negligence in the physician's non-disclosure.

40. *Id.* at 791-92 & n.124. See generally notes 17-21 *supra* and accompanying text.

41. *Id.* at 791-92.

42. *Id.* at 793.

43. But see *Ray v. Scheibert*, ____ Tenn. App. ____, 484 S.W.2d 63 (1972) (plain-

Canterbury represents a considerable movement away from traditional physician privileges and creates substantial rights of self-determination for patients. The District of Columbia court's thoughtful discussion of these issues was soon followed by two state supreme court decisions in Rhode Island and California.

In *Wilkinson v. Vesey*,⁴⁴ the plaintiff, who had received extensive x-ray treatment for a "shadow" in her chest, and who subsequently had eight operations to graft skin and remove much of her thoracic structure, claimed that her physicians were negligent in their diagnosis, their administration of the treatment and their failure to obtain her knowing consent prior to treatment.⁴⁵ The Supreme Court of Rhode Island reversed a lower court's directed verdict for the defendant-physicians and held that the plaintiff had presented sufficient evidence to send her case to the jury.⁴⁶ Reminiscent of *Canterbury*, the court held that the physicians' failure to obtain knowing consent gave rise to a claim of negligence;⁴⁷ that expert testimony, while relevant, would not be determinative of such a claim;⁴⁸ that a decision to undergo treatment is the patient's

tiff's suit barred by the statute of limitations because a physician's failure to adequately inform his patient was held to constitute a battery).

There are other ramifications of pleading a claim of battery rather than a claim of negligence. To prove battery, the patient must show that the physician "touched" him without authorization. The touching itself is the injury and entitles the "victim" to punitive or nominal damages as well as consequential damages for actual resulting harm. A physician's malpractice insurance may not cover liability arising from an intentional tort. See *Cobbs v. Grant*, 8 Cal. 3d 229, 240, 502 P.2d 1, 8, 104 Cal. Rptr. 505, 512 (1972), discussed in text accompanying notes 61-73 *infra*. For an enumeration of the elements of the negligence cause of action, see Note, Informed Consent—A Proposed Standard for Medical Disclosure, 48 N.Y.U.L. Rev. 548, 549-51 (1973). For elaboration of the differences between negligence and battery actions, see, e.g., *McCold, A Reappraisal of Liability for Unauthorized Medical Treatment*, 41 Minn. L. Rev. 381, 423-25 (1957), and other articles cited in 464 F.2d at 793 n.130. It has been argued, however, that when expert testimony determines the standard for measuring a physician's duty of disclosure, it makes little substantive difference (beyond the distinction in applicable statutes of limitations) whether the plaintiff's suit is in battery or negligence. See *Restructuring Informed Consent*, *supra* note 25, at 1557 n.67. Fraud offers a third possible cause of action. Such a suit requires proof that the physician knowingly misled the patient to induce him or her to consent. See, e.g., *Lopez v. Swyer*, 115 N.J. Super. 237, 279 A.2d 116 (1971).

44. 110 R.I. ___, 295 A.2d 676 (1972). There had also been an earlier decision in the case holding that the statute of limitations did not bar the action. *Wilkinson v. Harrington*, 104 R.I. 224, 243 A.2d 745 (1968).

45. 110 R.I. at ___, 295 A.2d at 681.

46. 110 R.I. at ___, 295 A.2d at 681, 685.

47. The court distinguished its own earlier ruling *Nolan v. Kechijian*, 75 R.I. 165, 64 A.2d 866 (1949), and held that recovery for the intentional tort of battery was appropriate only when the "procedure is completely unauthorized"; inadequate disclosure, in contrast, raised a claim of negligence. 110 R.I. at ___, 295 A.2d at 686. See also note 43 *supra*.

48. 110 R.I. at ___, 295 A.2d at 687-88. The court used the *Canterbury* rationale to eliminate the need for expert testimony. See notes 17-21, 40 & 41 *supra* and accompanying text.

undeniable right;⁴⁹ and that local medical community practice does not set the standard for sufficient disclosure.⁵⁰ Further paralleling *Canterbury*, *Wilkinson* held that adequacy of disclosure should be determined by a jury on the basis of the "materiality" of the facts;⁵¹ thus the physician has no duty to disclose those risks a patient is likely to or actually does know on the basis of past experience.⁵² Also as in *Canterbury*, one of the elements of the plaintiff's case is proof that, had he been duly informed of the risk of the procedure, he would not have given his consent.⁵³

The *Wilkinson* opinion, however, deviates from *Canterbury* in a few respects.⁵⁴ *Wilkinson's* extremely strong language, apparently granting the patient an absolute right of choice, goes somewhat beyond the *Canterbury* holding, which took careful account of the emergency situation.⁵⁵ Further, the Rhode Island court addressed the problem of adversity between the physician and patient on the necessity of the disclosure.⁵⁶ Third,

49. *Id.* at ____, 295 A.2d at 688.

50. *Id.* at ____, 295 A.2d at 688. See Torts, 1973/74 Ann. Survey Am. L. 131.

51. 110 R.I. at ____, 295 A.2d at 688-89, also citing Waltz & Scheuneman, *supra* note 28, at 640, for the definition of "materiality."

52. 110 R.I. at ____, 295 A.2d at 689, and cases cited therein.

53. *Id.* at ____, 295 A.2d at 690. In addition, the Rhode Island court proffered an argument (derived from 2 F. Harper & F. James, *Law of Torts* § 17.1 n.15 (Supp. 1968)), which distinguished the usual malpractice cases, where the physician and patient share the common goal of effecting a cure, from the duty-to-disclose cases, where the views of the physician and patient might be divergent. The patient may object to the physician's suggested treatment because risks in the patient's view outweigh the advantages. The *Wilkinson* court stated definitively that

every competent [adult has the] right to forego treatment, or even cure, if it entails what for him are intolerable consequences or risks however unwise his sense of values may be in the eyes of the medical profession, or even the community.

110 R.I. at ____, 295 A.2d at 687. Accord, *Erickson v. Dilgard*, 44 Misc. 2d 27, 252 N.Y.S.2d 705 (Sup. Ct. 1962) (finding final authority rested with the patient to refuse a life-saving blood transfusion). While the court failed to deal with the emergency situation (compare *Canterbury*, discussed in notes 29-32 *supra* and accompanying text), Harper and James propose that in a situation where an adult, voluntarily hospitalized, refuses life saving treatment, his desire should prevail. Harper & James, *supra*. But see *Application of President and Directors of Georgetown College, Inc.*, 331 F.2d 1000 (D.C. Cir.), cert. denied, 377 U.S. 978 (1964) upholding hospital's administration of a life saving blood transfusion to an objecting adult patient who was a Jehovah's Witness); *Jehovah's Witnesses of Wash. v. King County Hosp.*, 278 F. Supp. 488 (W.D. Wash. 1967), *aff'd per curiam*, 390 U.S. 598 (1968). *John F. Kennedy Mem. Hosp. v. Heston*, 58 N.J. 576, 580, 279 A.2d 670, 672 (1973). For discussion of an adult's first amendment right to refuse medical treatment see Note, *Compulsory Medical Treatment and the Free Exercise of Religion*, 42 Ind. L.J. 386 (1967).

54. See 110 R.I. at ____, 295 A.2d at 688, where the court states that its reasoning is different from *Canterbury's*.

55. 464 F.2d at 788-89. *Wilkinson* only mentioned the emergency situation incidentally, quoting *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914), which restricted such situations to times when a patient is unconscious and in need of immediate surgery.

56. 110 R.I. at ____, 295 A.2d at 687. See note 53 *supra*.

the *Wilkinson* decision arguably extended *Canterbury* by imposing the burden of disclosure upon *all* physicians of the treatment team.⁵⁷ Also, the Rhode Island court never explicitly assigned the burden of proof of the validity of non-disclosure.⁵⁸ This distinction between the opinions, however, may be only superficial since the language in *Wilkinson* suggests that, as in *Canterbury*, a rebuttable presumption of negligence arises once the plaintiff has demonstrated the physician's failure to disclose material facts.⁵⁹ Finally, in contrast to both *Canterbury's* careful discussion and *Wilkinson's* own generally broad statement of patients' rights, the Rhode Island court left a potential "loophole" in its protection by merely noting the therapeutic privilege doctrine without defining its scope or appropriate application.⁶⁰

The third major decision on a doctor's duty to disclose was issued seven days after *Wilkinson* by the Supreme Court of California sitting en banc in *Cobbs v. Grant*.⁶¹ In *Cobbs*, defendant-physician appealed a jury's general verdict of negligence as unsupported by the evidence and challenged the trial court's instructions on informed consent.⁶² The Supreme Court of California held that, in the face of medical facts "not commonly susceptible of comprehension by a lay juror," plaintiff's failure to introduce expert testimony in support of his claim of negligence by a physician for performance of surgery required a reversal of the judgment.⁶³ Because

57. *Id.* at ____, 295 A.2d at 689. In *Wilkinson*, a radiologist was included within this zone of duty. *Canterbury* probably failed to deal with this issue because the complaint at bar had named only one defendant, the operating surgeon. This oversight is unfortunate since it leaves open the question of who must make disclosures when treatment involves more than one physician.

58. Compare *Canterbury*, 464 F.2d at 791, placing this burden on the physician. See note 37 *supra* and accompanying text.

59. 110 R.I. at ____, 295 A.2d at 688.

60. The court simply stated:

The imposition of a duty of making disclosure is tempered by the recognition that there may be a situation where a disclosure should not be made because it would unduly agitate or undermine an unstable patient.

Id. at ____, 295 A.2d at 689. See also Univ. of Pa. Health Law Project, 8 Materials on Health Law, 34 (unpublished, rev'd ed. 1972). See also notes 33-36 *supra* and accompanying text.

61. 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972). The patient, Cobbs, suffered various infectious complications, requiring repeated surgery, which had arisen from the removal of a duodenal ulcer. Although Cobbs had consented to the initial surgery at the recommendation of his family doctor and the defendant surgeon, Dr. Grant, neither physician had warned him of the inherent risks in the operation. *Id.* at 234, 502 P.2d at 4, 104 Cal. Rptr. at 508.

62. *Id.* at 236, 502 P.2d at 5, 104 Cal. Rptr. at 509. For an earlier decision in the case on a different issue, see 100 Cal. Rptr. 98 (Cal. App. 1972).

63. 8 Cal. 3d at 236, 502 P.2d at 5, 104 Cal. Rptr. at 509. The court refused to find that this case fit within the "common knowledge exception." *Id.* at 237, 502 P.2d at 5-6, 104 Cal. Rptr. at 509. Compare *Canterbury*, 464 F.2d at 791-92, where the District of Columbia court also recognized the need for medical (expert) testimony for certain purposes such as determining the "risks of therapy and the consequences of leaving existing maladies untreated." *Id.* See note 41 *supra* and accompanying text.

the jury had rendered a general verdict and the grounds for liability could have been either negligence in his decision to operate or in his performance of the surgery, or alternatively, failure to obtain informed consent, the court remanded the case for a new trial. Recognizing that the question of informed consent would probably arise on retrial, the court expounded guidelines similar to the *Canterbury* standards for instructing the jury.⁶⁴ The court further clarified California law by effectively following *Canterbury* and *Wilkinson* to hold that failure to make adequate disclosure may lead to a claim of negligence.⁶⁵ The physician owes his patients a "duty of reasonable disclosure of the available choices with respect to proposed therapy and of the dangers inherently and potentially involved in each."⁶⁶ Fulfillment of such duty should be measured by general community, rather than medical, standards of reasonableness.⁶⁷ In viewing the physician-patient relationship as "fiducial" rather than paternalistic,⁶⁸ the court held that the patient's need for information measures the scope of the physician's duty.⁶⁹ While summarily recognizing the traditional exceptions to the above rule in cases where an emergency exists⁷⁰ or where

64. 8 Cal. 3d at 234, 502 P.2d at 4, 104 Cal. Rptr. at 508. See also *Canterbury*, 464 F.2d at 786.

65. 8 Cal. 3d at 240, 502 P.2d at 8, 104 Cal. Rptr. at 512. Battery was restricted to "those circumstances when a doctor performs an operation to which the patient has not consented." *Id.* See *Berkey v. Anderson*, 1 Cal. App. 3d 790, 82 Cal. Rptr. 67 (1969) (failure to disclose risks inherent in an exploratory surgical operation could constitute a technical battery). Cf. *Dow v. Kaiser Foundation*, 12 Cal. App. 3d 488, 90 Cal. Rptr. 747 (1970) (proof of willfully withheld material information without good medical reason is required to establish the claim of battery); *Carmichael v. Reitz*, 17 Cal. App. 3d 958, 95 Cal. Rptr. 381 (1971) (failure to disclose constituted negligence). The trend in other jurisdictions is not yet uniform. See, e.g., *Ray v. Scheibert*, ____ Tenn. App. ____, 484 S.W.2d 63 (1972). See note 43 *supra*.

66. 8 Cal. 3d at 243, 502 P.2d at 10, 104 Cal. Rptr. at 514. The court explicitly protected physicians for non-disclosure of minor or commonly known risks with relatively uncomplicated procedures. 8 Cal. 3d at 244, 502 P.2d at 11, 104 Cal. Rptr. at 515. Cf. note 15 *supra*. Compare *Canterbury*, 464 F.2d at 788, which, while excepting commonly known risks or those risks of which the patient is already aware, refused to limit the rule according to the size of the probability of the hazard occurring or the complexity of the procedure.

67. 8 Cal. 3d at 243, 502 P.2d at 10, 104 Cal. Rptr. at 514. The court used reasoning similar to that in *Canterbury*, 464 F.2d at 782, and *Wilkinson*, 110 R.I. at ____, 295 A.2d at 687. *Cobbs* rejected the prevailing "medical community" standards rule as "needlessly overbroad" because it gave "virtual absolute discretion" to the physician. 8 Cal. 3d at 243, 502 P.2d at 10, 104 Cal. Rptr. at 514.

68. 8 Cal. 3d at 246, 502 P.2d at 12, 104 Cal. Rptr. at 516.

69. *Id.* at 245, 502 P.2d at 11, 104 Cal. Rptr. at 515, quoting *Canterbury*, 464 F.2d at 786, using the "materiality" standard.

70. 8 Cal. 3d at 243, 502 P.2d at 10, 104 Cal. Rptr. at 514. *Cobbs* did not define the term "emergency" (but see *Canterbury*, 464 F.2d at 788), but held that when such a situation occurs, consent may be implied. Compare treatment of this issue in *Wilkinson* where the court merely alluded to the problem. 110 R.I. at ____, 295 A.2d at 685.

the patient is a minor or incompetent,⁷¹ the *Cobbs* court expressly tried to narrow the California interpretation of therapeutic privilege by placing the burden of proof as to its applicability upon the physician.⁷² Finally, under *Cobbs*, as in *Canterbury* and *Wilkinson*, the plaintiff must prove that, had he known the risks, he would have foregone the treatment.⁷³

As demonstrated by the foregoing summary, *Canterbury*, *Wilkinson*, and *Cobbs* represent a significant change in tort law. The magnitude of the departure is highlighted by a comparison of these three cases with *Natanson v. Kline*,⁷⁴ the landmark decision prior to *Canterbury* on physicians' duty to disclose. Decided by the Supreme Court of Kansas in 1960, *Natanson* imposed a legal duty on physicians to make reasonable disclosures to patients concerning the inherent hazards of a given treatment⁷⁵ and held that a doctor who had told his patient nothing of the risks of cobalt treatment failed as a matter of law in his duty towards her.⁷⁶ *Natanson* provided that the jury, as laymen, should decide whether any disclosure was made; but, in contrast to the 1972 decisions,⁷⁷ the adequacy of that disclosure was held to turn on reasonable medical practice and therefore necessitated expert testimony.⁷⁸

Possible explanations for the change in judicial orientation since *Natanson* are the articulation of new theories in the areas of patients' rights and tort law, and the recognition of the need to divest the physician of some of his unlimited power over a patient's body. Each of the 1972 decisions has as its implicit purpose the alleviation of plaintiffs' problems

71. 8 Cal. 3d at 244, 502 P.2d at 10, 104 Cal. Rptr. at 514. The court failed to define the term "incompetent," but did state that when treating such a patient, the physician must obtain consent from the patient's legal guardian or closest available relative. *Id.*

72. The physician must show by a preponderance of the evidence [that] he relied upon facts which would demonstrate to a reasonable man that disclosure would have so seriously upset the patient that the patient would not have been able to dispassionately weigh the risks of refusing to undergo the recommended treatment.
8 Cal. 3d at 246, 502 P.2d at 12, 104 Cal. Rptr. at 516. Accord, *Canterbury*, 464 F.2d at 789.

73. 8 Cal. 3d at 245, 502 P.2d at 11, 104 Cal. Rptr. at 515.

74. 187 Kan. 186, 354 P.2d 670 (1960).

75. *Id.* at 189, 354 P.2d at 673.

76. *Id.*

77. Only one decision before *Canterbury* had eliminated the requirement of expert testimony on the adequacy of disclosure. In *Woods v. Brumlop*, 71 N.M. 221, 377 P.2d 520 (1962), the Supreme Court of New Mexico held that physicians have a duty to disclose the nature, consequences and risks of treatments and that the sufficiency of any disclosure was an issue for the jury. Unlike *Canterbury*, *Wilkinson* or *Cobbs*, the plaintiff did not have to prove that the undisclosed knowledge would have deterred her from undergoing the therapy. The court may have reached this conclusion, however, as a result of evidence that the physician had affirmatively misled the patient by unwarranted reassuring statements.

78. 187 Kan. at 189, 354 P.2d at 673. Accord, W. Prosser, *The Law of Torts* § 88 (4th ed. 1971).

in securing favorable expert witnesses,⁷⁹ and each of the courts apparently were swayed by legal commentators who had criticized the requirement of such testimony.⁸⁰ Each opinion aspired to a physician-patient relationship based upon mutual trust.⁸¹ The Supreme Court of Rhode Island epitomized the thesis of these recent decisions in its statement that "more communication between doctor and patient means less litigation between patient and doctor."⁸²

While only future applications will demonstrate the true viability of these new guidelines,⁸³ there are already several points of confusion evident in the decisions.⁸⁴ None of the courts detailed disclosure requirements for treatments other than surgery.⁸⁵ Although *Cobbs* excludes "common procedures" from the disclosure requirement, no definition of what constitutes such a procedure is formulated.⁸⁶ Moreover, the scope of the therapeutic and emergency privileges still remains ill-defined.⁸⁷ Finally, these expanded concepts of patients' rights may be difficult to implement in view of the economic realities of the delivery of health care, particularly in clinics where a revolving set of doctors continually meet new patients and administer short-term treatments.⁸⁸

79. *Canterbury*, 464 F.2d at 792; *Wilkinson*, 110 R.I. at ____, 295 A.2d at 687; *Cobbs*, 8 Cal. 3d at 243, 502 P.2d at 10, 104 Cal. Rptr. at 513. Accord, 2 F. Harper & F. James, *The Law of Torts* § 17.1 n.15 (Supp. 1968).

80. See, e.g., *Canterbury*, 464 F.2d at 779, relying on Waltz & Scheuneman, *Informed Consent to Therapy*, supra note 28, and on *Restructuring Informed Consent*, supra note 25, at 1533 (1970); *Wilkinson*, 110 R.I. at ____, 295 A.2d at 685, 687, relying upon Waltz & Scheuneman, supra, *Restructuring Informed Consent*, supra note 25, and Harper & James, supra note 79; *Cobbs*, 8 Cal. 3d at 243, 502 P.2d at 10, 104 Cal. Rptr. at 514, referring to Comment, 75 Harv. L. Rev. 1445 (1962), and Waltz & Scheuneman, supra.

81. Cf. *Canterbury*, 464 F.2d at 782; *Wilkinson*, 110 R.I. at ____, 295 A.2d at 690; *Cobbs*, 8 Cal. 3d at 246, 502 P.2d at 12, 104 Cal. Rptr. at 516.

82. 110 R.I. at ____, 295 A.2d at 690.

83. For the purposes of this discussion the writers consider the standards promulgated by the three courts to be essentially the same.

84. Many questions inevitably arise from the courts' language formulating the patients' right to informed consent. In addition, consider related questions such as who "owns" or should have access to patients' medical records, if they actually have an expansive right to know? See Dep't of Health, Educ. & Welfare, *Report of the Secretary's Comm'n on Medical Malpractice*, Publication No. (OS) 73-88 (1973) (hereinafter cited as HEW Report). See also Univ. of Pa. Health Law Project, 8 *Materials on Health Law* 62 (unpublished, rev'd ed. 1972).

85. Cf. note 15 supra.

86. See note 66 supra.

87. See notes 29-36, 55, 60 & 70-72 supra and accompanying text. See Note, *Consent to Surgery—A Dilemma*, 37 Albany L. Rev. 591 (1973), for a review of inconsistent judicial definitions in New York of the term "emergency."

88. See HEW Report, supra note 84, at 3. There are many unanswered practical questions which arise particularly in this context: Do the courts' guidelines achieve the "delicate balance between the right of the patient to choose the treatment he wishes to undergo and the freedom of the physician to practice responsible and progressive medicine without fear of frequent litigation"? (*Dunham v. Wright*, 423 F.2d 940,

The impact of the *Canterbury*, *Wilkinson*, and *Cobbs* decisions has been disappointing thus far since both federal and state courts have relied upon the traditional standards. For example, in a malpractice suit involving a well-known heart specialist, a federal district court in Texas directed a verdict for the defendant and followed earlier Texas law to hold that the duty of a physician to disclose information is measured by the community medical practice.⁸⁹ Furthermore, using vague language, the court designed a broad version of the therapeutic privilege permitting "each doctor [to] use his medical judgment as to whether certain disclosures of risks would have an adverse effect on the patient so as to jeopardize the success of the proposed therapy."⁹⁰

A federal district court in Pennsylvania also supported a physician's right to determine the sufficiency of his disclosure to his patients in *Ciccarone v. United States*.⁹¹ While noting that Pennsylvania law required a physician to obtain informed consent, the district court dismissed plaintiff's claim that the physician had negligently discharged this duty, even though he had failed to tell the patient of the alternatives available to the proposed treatment. The court reasoned that it could not "place a doctor in the position of talking a patient out of treatment which he [the physician] reasonably believe[d] to be necessary and safe."⁹²

In *Collins v. Itoh*,⁹³ the Supreme Court of Montana endorsed the discretionary powers of a physician by affirming a directed verdict in favor of a physician-defendant in a malpractice action. The court, in the face of unusually significant omissions by the defendant surgeon, rejected the patient's claim that the physician had breached his duty to disclose.⁹⁴ The court held that the plaintiff had failed to produce the expert testi-

942 (D.C. Cir. 1970), cited in *Canterbury*, 464 F.2d at 780). Has the physician the time to make a disclosure adequate to the courts' requirements? Is there a real opportunity for the patients' right of self-determination to be observed in the pressured atmosphere of a busy urban clinic? How can such a right find expression when health care is economically beyond the reach of some?

89. *Karp v. Cooley*, 349 F. Supp. 827, 833 (S.D. Tex. 1972).

90. *Id.* at 834, quoting earlier Texas cases. The decision, however, may be explained by the facts at bar. The court had heard persuasive testimony that the physicians had explained the nature of the heart surgery in detail to both the deceased patient and his widow, the plaintiff. Furthermore, the plaintiff's credibility was undercut because previously she had been most pleased with the physicians' efforts on her husband's behalf, having written numerous laudatory letters on the subject. 349 F. Supp. at 829-32.

91. 350 F. Supp. 554 (E.D. Pa. 1972).

92. *Id.* at 563.

93. 160 Mont. ____, 503 P.2d 36 (1972).

94. *Id.* at ____, 503 P.2d at 40-41. The court's decision is striking because the physician had not only failed to warn the patient, prior to her thyroidectomy, of the potential risks involved, but also post-operatively had withheld the fact that during the operation he had inadvertently removed the parathyroid (four small endocrine glands located adjacent to the thyroid). *Id.*, 503 P.2d at 40.

mony on medical custom and practice⁹⁵ needed to establish the doctor's negligence.⁹⁶

In another recent case,⁹⁷ a Louisiana appellate court sharply diverged from the *Canterbury* concept that a patient has the right to control what is done with her body.⁹⁸ A woman charged her physicians with malpractice in their performance of a modified radical hysterectomy. She further alleged that she had not consented to as extensive surgery as was performed.⁹⁹ The court affirmed the lower court's verdict for the defendants and granted the doctor wide discretion on the basis of the patient's general consent to the operation.¹⁰⁰

In conclusion, there is still a lack of unanimity on the breadth of a physician's duty to disclose to patients the risks of treatments.¹⁰¹ While the obvious thrust of *Canterbury* is to limit the prerogative of a physician and to enforce the right of a patient to choose the therapy he will undergo, it remains to be seen whether other courts will adopt its position largely rejecting the requirement of expert testimony and the broad therapeutic privilege. As the fear of malpractice suits against physicians grows and the concern of patients for proper care continues,¹⁰² the need for a clear and practical rule will intensify.

II

THE PATIENT'S ABILITY TO GIVE CONSENT

THE ELEMENTS OF CONSENT: A CASE STUDY—MENTALLY ILL PATIENTS

As discussed in Part I, many courts within the last year have explored a physician's duty to disclose information and obtain informed consent;¹⁰³ none of these cases, however, actually addressed the issue of *who* is capable of giving such consent. Although some of the courts raised the issue of competency to consent by noting Justice Cardozo's words that "[e]very human being of adult years and sound mind has a right to de-

95. *Id.* at ____, 503 P.2d at 41. See *Negaard v. Estate of Fedt*, 152 Mont. 47, 446 P.2d 436 (1968) (using the medical rather than a community standard of care).

96. 160 Mont. at ____, 503 P.2d at 41.

97. *Bryant v. St. Paul Fire and Marine Ins. Co.*, 272 So. 2d 448 (La. App. 1973).

98. 464 F.2d at 780.

99. 272 So. 2d at 453.

100. *Id.* The court stated that the general consent "included her consent for the surgeon to perform whatever was necessary to remove the potentially dangerous cancerous tissues." *Id.*

101. Cf. Torts, 1966 Ann. Survey Am. L. 209, 232. Under pre-*Canterbury* doctrines, the authors commented on the unsettled law at that time and concluded that only in cases where adverse circumstances were certain (e.g., sterilization) was a burden clearly placed upon a physician to detail the risks to his patient.

102. See National Broadcasting Co. Reports, Hospitals, Doctors, and Patients, transcript of telecast September 22, 1973, available upon written request to the company at 30 Rockefeller Plaza, New York, New York.

103. See, e.g., note 5 *supra*.

termine what shall be done with his own body,"¹⁰⁴ these opinions did not interpret his statement or explain how to apply the criteria he expounded. However, a Michigan circuit court confronted the question directly in *Kaimowitz v. Michigan Department of Mental Health*¹⁰⁵ when it determined whether an adult male, involuntarily confined in a mental hospital, could give legally valid consent to an experimental psychosurgical procedure. This decision, issued at a time when great attention is being focused on the rights of the confined mentally ill,¹⁰⁶ has critical implications for the physician-patient relationship and raises considerable questions as to the practical accuracy of Cardozo's statement.

Kaimowitz was decided by the Circuit Court for the County of Wayne, Michigan, on a writ of habeas corpus which charged that a John Doe was being detained illegally for the purpose of experimental psychosurgery.¹⁰⁷ Doe, committed in 1955 under a subsequently repealed Criminal Sexual Psychopathic law,¹⁰⁸ was to serve as the only subject of an experiment conducted by two physicians associated with the Michigan Department of Mental Health and funded by the Michigan legislature.¹⁰⁹ The experiment had sought to compare the effects of psychosurgery on the amygdaloid portion of the limbic system of the brain with the effects of the drug cyproterone acetate on the male hormonal flow, in order to ascertain if either method could control male aggression and thus relieve a patient's suffering from rages.¹¹⁰ Both John and his parents had signed consent forms¹¹¹ which detailed the goals of the operation, the nature of

104. In *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914), quoted in *Canterbury*, 464 F.2d at 780, and in *Wilkinson*, 110 R.I. at ____, 295 A.2d at 685, and paraphrased in *Cobbs*, 8 Cal. 3d at 243, 104 Cal. Rptr. at 513, 502 P.2d at 9.

105. *Kaimowitz v. Michigan Dep't of Mental Health*, Civ. No. 73-19434-AW (Mich. Cir. Ct. July 10, 1973), noted in 42 U.S.L.W. 2063 [All subsequent citations shall refer to the slip opinion. Any relevant references appearing in the United States Law Week report shall also be noted.]

106. See, e.g., *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971) appeal pending, No. 72-2634 (5th Cir. 1972) and *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972), vacated and remanded for clarification of order, 42 U.S.L.W. 3402 (U.S. Jan. 15, 1974) (No. 73-568).

For a general discussion of the rights of mental patients, see B. Ennis & L. Siegel, *Rights of Mental Patients* (1973); B. Ennis, *Prisoners of Psychiatry* (1972).

107. Civ. No. 73-19434-AW, at 1, 42 U.S.L.W. at 2063.

108. See *id.* at 2 n.2. This provision is now codified at Mich. Comp. Laws § 330.356 (Supp. 1973). See note 115 *infra* and accompanying text.

109. Civ. No. 73-19434-AW, at 2-3. Doe was the only subject because the experimenters could not locate any other suitable patients. *Id.* at 3. The criteria for the population were listed in the court's appendix. *Id.* at Appendix, Item 2, at 7.

110. *Id.* at 3. See *id.* at Appendix, Item 1, at 1 for a fuller explanation of the experimental proposal.

111. *Id.* at 4-5. There was some dispute, however, as to whether the parents had agreed to all the procedures or only the initial stages. *Id.* at 5 n.6. In addition, the patient withdrew his consent during the trial. *Id.* at 8 n.9. Nevertheless, the court had held in its first opinion issued on March 15, 1973, that neither Doe's withdrawal of

the procedure, and both the inherent and potential risks. After two specially appointed review committees¹¹² had approved the treatment on scientific, moral and ethical grounds, the doctors implanted depth electrodes in John Doe's brain as the first stage of the experiment.¹¹³ At this point, plaintiff halted the project by filing suit as a representative of Doe and a public interest group, the "Medical Committee for Human Rights."¹¹⁴

A three-judge court, in an opinion issued in March of 1973, declared Doe's detention unconstitutional and later ordered his release.¹¹⁵ In July of 1973, the same court issued its landmark and unanimous decision that involuntarily detained mental patients are incapable of giving informed, and therefore legally adequate, consent to experimental psychosurgical procedures on the brain.¹¹⁶

There were two fundamental but intertwined bases for the latter opinion: the unusually experimental and unpredictable nature of the particular psychosurgical procedure¹¹⁷ and the involuntary incarceration status of the patient.¹¹⁸ For the purposes of this case, the court defined psychosurgery¹¹⁹ narrowly to be that psychosurgery which was highly experimental,¹²⁰ was rife with unknown risks¹²¹ and irreversible consequences,¹²² and was of only indeterminate benefit to either the patient or

consent, nor his release after a finding that his detention was unconstitutional (see note 115 *infra* and accompanying text) had rendered the issue moot. *Id.* at 7 & n.8. For the text of the consent form, see *id.* at 3-4 n.5.

112. *Id.* at 5. The experimenters' themselves had created the committees, one called the Scientific Review Committee and the other, the Human Rights Review Committee.

113. *Id.*

114. *Id.* The Medical Committee for Human Rights (MCHR) is a national organization of medical students and physicians which focuses its attention upon the rights of patients and the delivery of health care. The case was apparently very well briefed and argued by Dean Frances A. Allen and Prof. Robert A. Burt of the University of Michigan Law School, both appointed counsel for John Doe. *Id.* at 6, 41.

115. See *id.* at 6. The criminal sexual psychopath statute under which John Doe had been committed had been repealed by the Michigan legislature in 1968. *Id.* at 2 n.2.

116. *Id.* at 31, 42 U.S.L.W. at 2064.

117. See notes 119-23 *infra* and accompanying text.

118. See notes 124, 131, 132, 135, 137 & 138 *infra* and accompanying text. Because of the unusual circumstances facing the Michigan court, it is possible that other courts, confronted with less dramatic modes of treatment, may limit the *Kaimowitz* holding to its facts.

119. Civ. No. 73-19434-AW, at 10, 42 U.S.L.W. at 2063. Other definitions of psychosurgery had been offered to the court and rejected by it. *Id.* at 9-10.

120. *Id.* at 26-27, 42 U.S.L.W. at 2063. Expert testimony established the experimental nature of the procedure. See *id.* at 12, 42 U.S.L.W. at 2063.

121. *Id.* at 11-12, 42 U.S.L.W. at 2063. The court noted the constant interdependence among the areas of the brain. *Id.*

122. *Id.* at 12, 42 U.S.L.W. at 2063. Because of the biological fact that once brain cells are destroyed, they do not regenerate, any physical intervention in the brain has "irreversible" consequences and is by definition a "treatment of last resort." *Id.* Further, psychosurgery that has been done has been associated with a general blunting

society.¹²³ The court found the circumstances of an involuntarily confined patient relevant because the inherently coercive nature of the institutions which restrict an individual's activities often prompt patients to seek special attention as a source of relief from this debilitating monotony.¹²⁴

In reaching its decision to modify John Doe's ability to consent to these procedures, the court considered elementary tort law. Holding that "informed consent is a requirement of variable demands," the court noted the increased importance of consent in experimental procedures¹²⁵ and the heightened need for close scrutiny of the adequacy of that consent.¹²⁶ The court outlined the standard elements of informed consent as competency, knowledge, and voluntariness.¹²⁷ It then analyzed whether an involuntarily confined mental patient could ever fulfill these criteria.¹²⁸

The court defined "competency" as "the ability of the subject to understand rationally the nature of the procedure, its risks, and other relevant information."¹²⁹ Significantly, the court never suggested that either an individual's mental illness¹³⁰ or his confinement were dispositive of this issue. Rather, the involuntary detention undermined a patient's capacity to consent to the psychosurgical procedure, and was thus one

of emotions and a reduction in spontaneous behavior, a loss of capacity for learning and an impairment of memory. *Id.* at 17, 42 U.S.L.W. at 2064.

123. *Id.* at 13-17, 42 U.S.L.W. at 2063. There was no definitive evidence that this surgical-medical treatment would ameliorate Doe's problem of violent behavior. *Id.*

124. See *id.* at 29, 33, 42 U.S.L.W. at 2064.

125. *Id.* at 22, 42 U.S.L.W. at 2063-64. The court, citing J. Katz, *Experimentation with Human Beings* 523 (1972), ascribed the following functions to consent: emphasizing the individual's right to choose, encouraging the subject to be an active partner, encouraging the investigator to question his project, and increasing society's awareness of the research. Civ. No. 73-19434-AW, at 19-20.

126. In reaching its decision, the court reasoned that its review of the consent given varies with the nature of the treatment contemplated. "When a procedure is experimental, dangerous and intrusive, special safeguards are necessary." *Id.* at 22, 42 U.S.L.W. at 2063-64. Consider the implications for the duty-to-disclose cases, discussed at notes 1-102 and accompanying text. One might ask whether the requirements of a physician's disclosure itself should vary with the procedure involved. See, e.g., *Canterbury*, 464 F.2d at 786-87, mandating that it is the patient's need for the information which governs the duty to disclose.

127. Civ. No. 73-19434-AW, at 22, 31, 42 U.S.L.W. at 2064.

128. *Id.* at 22-32, 42 U.S.L.W. at 2064, quoting the ten principles known as the "Nuremberg Code," enumerated in the "Judgment of the Court in United States v. Karl Brandt," *Trial of War Criminals before the Nuremberg Military Tribunals*, Vol. 1 & 2, "The Medical Case," U.S. Gov't Printing Office, Wash., D.C. (1948), reprinted in Katz, *Experimentation with Human Beings* 305 (1972). *Id.* at 23-24. See 289 N. Eng. J. Med. 325 (Aug. 9, 1973) for discussion on the problem of obtaining informed consent in an institutionalized setting.

129. *Id.* at 25, 42 U.S.L.W. at 2064, and citing Waltz & Scheuneman, *supra* note 28. See *Canterbury*, 464 F.2d at 787.

130. John Doe reportedly had an I.Q. of at least 80, and it was suggested that he had sufficient mental acuity to comprehend both the treatment and his circumstances. Civ. No. 73-19434-AW, at 25.

among several pertinent factors to be considered.¹³¹ The court concluded that the institutional setting here rendered John Doe, as well as a legal guardian, incapable of giving consent to the proposed operation.¹³² The court further held that, since it had defined the psychosurgical procedure as highly experimental,¹³³ satisfaction of the requirement of knowledge of the risks was "literally impossible."¹³⁴ Finally, the voluntariness element of informed consent was found to be fundamentally absent due to the patient's long-term and involuntarily detained status.¹³⁵

The court was careful to emphasize in its conclusion that neither the psychosurgery procedure in general nor the coerced confinement for mental health purposes was a complete bar to valid consent. If this psychosurgery ever became an accepted neurosurgical procedure, then "it is possible, with appropriate review mechanisms,¹³⁶ that involuntarily detained mental patients could consent to such an operation."¹³⁷ Further, the court held that "an involuntarily detained mental patient today can give adequate consent to accepted neurosurgical procedures."¹³⁸ Nevertheless, until these conditions were satisfied, the court concluded that the state had an obligation to prevent the experiment's occurrence.¹³⁹

In addition to the common law bases for the holding, the *Kaimowitz* court advanced "compelling constitutional considerations that preclude[d] involuntarily detained mental patients from giving effective consent to this type of surgery."¹⁴⁰ Premising its discussion upon the fact that John Doe was detained at the instance of the state, thereby implicating doctrines of state action,¹⁴¹ the court held that state authorization of experimental psychosurgery would violate Doe's right to freedom of speech¹⁴² and to privacy.¹⁴³ Using innovative analysis, the court determined that

131. This conclusion arguably should provoke closer scrutiny into consent given by any patient who is involuntarily confined and who agrees to treatment procedures.

132. *Id.* at 25-26, 42 U.S.L.W. at 2064. See note 135 *infra*, and text accompanying note 124 *supra*.

133. See text accompanying notes 119-23 *supra*.

134. Civ. No. 73-19434-AW, at 27, 42 U.S.L.W. at 2064.

135. *Id.* at 28, 42 U.S.L.W. at 2064. The court noted that the inequality of authority between mental patients and the physicians clouds any choices by the latter. *Id.* at 29, 42 U.S.L.W. at 2064. This fact raises doubts about conclusions that other institutionalized patients can give voluntary and knowledgeable consent to less dramatic treatments. *Id.* at 21, 42 U.S.L.W. at 2064. See note 131 *supra*.

136. See notes 125 & 126 *supra* and accompanying text.

137. *Id.* at 40.

138. *Id.*

139. This is an interesting posture for the court to take. While arguably an admirable decision under the facts of this case, there is a potential for abuse since, under the guise of paternalism, the state limits the options of an institutionalized person.

140. *Id.* at 32.

141. *Id.*, 42 U.S.L.W. at 2064.

142. *Id.*, 42 U.S.L.W. at 2064.

143. *Id.* at 36, 42 U.S.L.W. at 2064.

the first amendment protections extended to the generation of ideas.¹⁴⁴ In comparison to psychosurgery's potential to irreparably injure an individual's mental processes, the state was unable to demonstrate any sufficiently compelling interests to warrant overriding the patient's first amendment guarantees. Similarly, an individual's mind was also protected under the Supreme Court's elusively defined right to privacy.¹⁴⁵ The compelling state interest test was applied, and again the state's interest was held inadequate to justify the intrusive medical procedure.¹⁴⁶

While the logic of the *Kaimowitz* theory is enticing, that in order to enjoy an "effective" freedom to speak one must be able to think, it relies upon debatable constitutional foundations.¹⁴⁷ First of all, the United States Supreme Court has not delineated what it considers "effective" speech. No cases have actually mandated that there is any right to attain a certain level of competence or that individuals possess uniform abilities to exercise first amendment freedoms.¹⁴⁸ Second, the *Kaimowitz* court found no cases in point and was therefore forced to rely upon general statements by legal scholars and dicta in several earlier Supreme Court decisions.¹⁴⁹ The most probative precedent cited by the Michigan court was *Stanley v. Georgia*,¹⁵⁰ a case in which the Supreme Court implicitly recognized and protected the interrelationship among the human mind, the right of expression, and the right to privacy.¹⁵¹ The *Kaimowitz* reasoning was

144. *Id.* at 35, 42 U.S.L.W. at 2064. The court relied upon *Stanley v. Georgia*, 394 U.S. 557 (1969); *Whitney v. California*, 274 U.S. 357 (1927); *Abrams v. United States*, 250 U.S. 616 (1919); B. Cardozo, *The Paradoxes of Legal Science*, Selected Writings of Benjamin Nathan Cardozo 317-18 (1947); Emerson, *Toward a General Theory of the First Amendment*, 72 Yale L.J. 877 (1963). Unfortunately the facts of *Stanley* (the situs of the acts in question and the transitory nature of the activity (reading)) render the case easily distinguishable from *Kaimowitz*; however, given the unique nature of the *Kaimowitz* litigation, the court was forced to reason by analogy.

145. *Id.* at 36, 42 U.S.L.W. at 2064. The court reasoned that constitutional protection of one's mind is at least as deserving as other already recognized ideals. See *Roe v. Wade*, 410 U.S. 113 (1973) (one's body); and *Stanley v. Georgia*, 394 U.S. 557 (1969) (one's home); *Griswold v. Connecticut*, 381 U.S. 479 (1962) (marital bed).

146. Civ. No. 73-19434-AW, at 39, 42 U.S.L.W. at 2064.

147. See note 144 *supra*.

148. Cf. *San Antonio School District v. Rodriguez*, 411 U.S. 1 (1973), where the court rejected the appellants' equal protection argument that equal educational opportunities were necessary to an informed and intelligent exercise of first amendment freedoms by stating that there is no "guarantee to the citizenry of the most effective speech." *Id.* at 35-36. In any case, it would always have to be recognized that discrepancies will exist among individuals' innate capabilities. In addition, there are many circumstances in which the Court has justified limitations on individuals' right to exercise certain of their first amendment rights at all. See, e.g., *United States Civil Service Comm'n v. National Ass'n of Letter Carriers*, 93 S. Ct. 2880 (1973).

149. See, e.g., cases cited in notes 144 & 145 *supra*.

150. 39 U.S. 557 (1969) (conviction for possession of obscene matter in private held unconstitutional).

151. *Id.* at 564-66. The first amendment permits a person to "satisfy his intellectual and emotional needs in the privacy of his own home" and prohibits the government from exercising control over people's minds and private thoughts. *Id.* at 565.

also founded upon the preferred constitutional position of the first amendment, upon the highly personal and thereby potentially fundamental nature of the rights involved, and upon the very unusual fact situation presented.¹⁵² It is disappointing, however, that the court did not fully explore the implications of its constitutional premises nor detail the controversial issues over which it glided.

In summary, the *Kaimowitz* court did not conclude that involuntarily detained mental patients categorically lack the capacity to give informed consent, but rather it recognized that there are procedures for which the state could not allow such patients to give consent.¹⁵³ The person who is involuntarily institutionalized is specially situated by the state, which must then afford him or her additional protections. One must note, however, that ostensible protections can function as disabilities and that the result reached by the court means that the ambit of free choice with respect to personal health decisions¹⁵⁴ is further restricted for this class of people.

Even before *Kaimowitz*, other courts had considered the ability of mental patients to give consent to a proposed treatment. In *New York City Health and Hospitals Corp. v. Stein*,¹⁵⁵ a city hospital had voluntarily applied for court authorization¹⁵⁶ to give electroshock treatments to an adult female patient, diagnosed as schizophrenic and involuntarily retained,¹⁵⁷ who had refused to consent to the therapy. The hospital sought to dispense with the patient's consent "on the ground that she is incompetent to make a reasoned decision."¹⁵⁸ The court rejected the hospital's petition, reasoning that since the patient would suffer the consequences of an erroneous decision, her refusal should be determinative unless she lacked the mental capacity to "knowingly consent or withhold her consent."¹⁵⁹ With this presumption of competency, the court cautiously considered the conflicting testimony of the psychiatric witnesses for both parties. Ordering further retention of the patient, the judge nevertheless held that she did have the mental capacity to refuse treatment.¹⁶⁰

152. This is apparently the only reported case dealing with the problems involved in psychosurgery. American Civil Liberties Union Newsletter (1973).

153. See note 135 *supra* and accompanying text.

154. See *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914), and cited by *Kaimowitz*, Civ. No. 73-19434-AW, at 18.

155. 70 Misc. 2d 944, 335 N.Y.S.2d 461 (Sup. Ct. 1972).

156. *Id.* at 944-45, 335 N.Y.S.2d at 463. The hospital had applied under a statute which was not to take effect until the following January. See N.Y. Mental Hygiene Law § 15.03(b) (McKinney Supp. 1973).

157. See N.Y. Laws [1964], ch. 738, § 5, as amended, N.Y. Mental Hygiene Law §§ 31.27 & 31.29 (McKinney Supp. 1973).

158. 70 Misc. 2d at 945, 335 N.Y.S.2d at 463.

159. *Id.* at 946, 335 N.Y.S.2d at 464.

160. *Id.* at 946-47, 335 N.Y.S.2d at 465.

Both *Stein* and *Kaimowitz* lend support to the proposition that hospitalized mental patients should not be presumed "incompetent" solely as a result of their mental disability or their confinement. These decisions each suggest that, as with any other patients, physicians have a duty to disclose information to the mentally ill and must obtain their informed consent before instituting therapy.¹⁶¹ Unfortunately, neither of these cases addressed the problem of defining what characteristics or what standard of proof are required to render an adult incompetent to determine his medical treatment. Further, jurisdictions vary greatly on the capacities they ascribe to the mentally ill. Some states, such as New Jersey¹⁶² and New York,¹⁶³ provide by statute that hospitalization is not presumptive of incompetency to exercise civil rights. Case law in New York upholds the involuntarily detained's right to choose his hospital status¹⁶⁴ and to refuse treatment.¹⁶⁵ In Wisconsin, however, involuntary confinement in a mental institution raises a statutory rebuttable presumption of incompetency.¹⁶⁶

Legal procedures for evaluating incompetency to make personal health decisions vary considerably. Where involuntary confinement is evidence of incapacity, the commitment proceeding has been used as the forum for the adjudication of an adult as incompetent to make medical decisions;¹⁶⁷ but where detention by the state is not presumptive of in-

161. See "right to informed consent" cases cited at note 3 *supra*. See, e.g., *Kaimowitz*, Civ. No. 73-19434-AW, at 18 & n.18, 19-21, 42 U.S.L.W. at 2064. For a similar conclusion on the more limited issue of the right to refuse hospitalization for mental illness, see *Lessard v. Schmidt*, 349 F. Supp. 1078, 1094 (E.D. Wis. 1972), vacated and remanded for clarification of order, 42 U.S.L.W. 3402 (U.S. Jan. 15, 1974) (No. 73-568) (holding unconstitutional Wisconsin's procedures for civil commitment of the mentally ill).

162. See N.J. Stat. Ann. § 30:4-24.2 (Supp. 1973). This section, entitled "Rights of Patients," was applied in *Bush v. Kallen*, 123 N.J. Super. 175, 302 A.2d 142 (1973) (patients' attorneys have authority to inspect their clients' medical records if patients consent, in spite of patients' involuntary institutionalization).

163. N.Y. Mental Hygiene Law § 29.03 (McKinney Supp. 1973). See also N.Y. Mental Hygiene Law § 15.01 (McKinney Supp. 1973) which provides that "no person shall be deprived of any civil rights . . . solely by reason of receipt of services for a mental disability."

164. See *In re Buttenow*, 23 N.Y.2d 385, 244 N.E.2d 677, 297 N.Y.S.2d 97 (1968), discussed at notes 171-77 *infra* and accompanying text. See also *In re Curry*, 470 F.2d 368, 372 n.8 (D.C. Cir. 1973).

165. See *Winters v. Miller*, 446 F.2d 65 (2d Cir. 1971), reversing a summary judgment in defendants' favor on the ground that a hospital's psychiatric staff violated the first amendment by forcibly administering medication over the patient's protests based upon Christian Scientist beliefs. In its opinion, the court reaffirmed the general principle that "[a]bsent a specific finding of incompetence, the mental patient retains his right to sue or defend in his own name, to sell or dispose of his property, to marry, to draft a will, and, in general to manage his own affairs." *Id.* at 68.

166. Wis. Stat. Ann. § 51.005(2) (1951). See *Lessard v. Schmidt*, 349 F. Supp. 1078, 1088-89 (E.D. Wis. 1972), vacated and remanded for clarification of order, 42 U.S.L.W. 3402 (U.S. Jan. 15, 1974) (No. 73-568), enumerating other disabilities imposed by statute upon those adjudged mentally ill in Wisconsin.

167. See *Lessard v. Schmidt*, 349 F. Supp. 1078, 1088 (E.D. Wis. 1972), vacated and remanded for clarification of order, 42 U.S.L.W. 3402 (U.S. Jan. 15, 1974) (No. 73-568).

capacity,¹⁶⁸ no legal procedure exists to find a person incompetent to consent to medical treatment. The general civil incompetency hearing is usually inadequate for medical competency purposes because most state statutes focus solely upon the ability of an individual to manage his financial and proprietary affairs,¹⁶⁹ a standard distinct from the evidence relevant to competency to understand one's medical problems.

A second unresolved issue is the scope of authority of a court-appointed guardian, without specific court authorization, to make health care decisions for an adjudicated incompetent.¹⁷⁰ In the leading New York case, *In re Battenow*,¹⁷¹ the Court of Appeals of New York permitted an adjudicated incompetent—and not her committee¹⁷²—to decide her hospitalization status.¹⁷³ Her committee had protested the plaintiff's choice to become a voluntarily hospitalized patient because the voluntary status lacked the procedural safeguards given to the involuntary status.¹⁷⁴ Judge Fuld first liberally construed the former New York Mental Hygiene Law¹⁷⁵ to render it constitutional, holding that there were the same safeguards for both categories.¹⁷⁶ He then concluded that "an adjudication of incompetency is in no way a decision or judgment that the person so adjudicated may not act in matters involving his personal status."¹⁷⁷

As the foregoing discussion demonstrates, courts have not yet articulated the criteria which should govern the determination that an adult is incapable of making health care decisions.¹⁷⁸ Because courts are now

168. The fact of a patient's detention should not be used to determine capacity since involuntary confinement statutes present standards to determine the need for hospitalized care and treatment, factors which may be unrelated to a patient's general ability to consent to treatment. See, e.g., N.Y. Mental Hygiene Law § 35.01 (McKinney Supp. 1973).

169. E.g., N.Y. Mental Hygiene Law § 78.01 (McKinney Supp. 1973). Cf. note 168 *supra*.

170. E.g., *Strunk v. Strunk*, 455 S.W.2d 145 (Ky. 1969). See notes 190-334 *infra* and accompanying text for a discussion of the authority of a parent or the state to consent to treatments for a child.

171. 23 N.Y.2d 385, 244 N.E.2d 677, 297 N.Y.S.2d 97 (1968), rev'g 29 App. Div. 2d 538, 285 N.Y.S.2d 223 (2d Dep't 1967).

172. New York courts are empowered to appoint a committee which acts under judicial supervision to maintain the incompetent's property and other affairs. See N.Y. Mental Hygiene Law § 78.01 et seq. (McKinney 1972).

173. 23 N.Y.2d at 388, 244 N.E.2d 678, 297 N.Y.S.2d 99. The patient had switched herself from an "involuntarily" hospitalized status to a "voluntary" patient. *Id.*

174. *Id.*

175. N.Y. Laws [1927], ch. 426, § 7, as amended, N.Y. Mental Hygiene Law §§ 31.13 to 31.25 (McKinney Supp. 1973).

176. 23 N.Y.2d at 393, 244 N.E.2d at 681, 297 N.Y.S.2d at 103.

177. *Id.* at 394, 244 N.E.2d at 682, 297 N.Y.S.2d at 104.

178. See *Matter of Long Island Jewish-Hillside Medical Center*, 73 Misc. 2d 395, 342 N.Y.S.2d 356 (Sup. Ct. 1973), where the court had to determine if a hospital could operate on a severely debilitated elderly patient who had intermittently opposed the procedure. The court held he was unable to make health judgments, but its reasoning was unclear. The only "rule" to be drawn from the case is that aged adults with

confronted with the issue of an adult's ability to decide health care matters,¹⁷⁹ the author suggests that courts would benefit from the consistent application of the following test, derived from the decisions in *Canterbury v. Spence*,¹⁸⁰ *Kaimowitz v. Michigan Department of Mental Health*,¹⁸¹ and *New York Health and Hospitals Corp. v. Stein*.¹⁸² An individual should be considered competent to consent to or refuse treatment if he can understand the information which a physician is under a legal duty to impart to him concerning the risks, benefits, and alternatives to a proposed treatment. Moreover, a rebuttable presumption of competence should be utilized in every case. Expert testimony should be admissible to explain the condition of the patient, the nature of the proposed therapy, and the magnitude of risks involved, but such testimony should not be conclusive on the competency issue, since the decision to undergo treatment is a non-medical judgment.¹⁸³ Relevant topics of inquiry on the question of competency should include the patient's intelligence,¹⁸⁴ emotional state, ability to handle personal affairs, and the reasons proffered for acceptance or refusal of treatment. Furthermore, as *Kaimowitz* demonstrates, certain circumstances (such as lengthy institutionalization) may diminish an individual's capacity and thus necessitate inquiry into a patient's history. Determinations of incompetency as to health matters should be based upon a preponderance of the evidence that the patient is incapable of comprehending the information given to him by his physician. A court should be able to impose its own judgment of what is best for the patient only when the patient has been expressly adjudicated incapable of making his or her own health care decisions.¹⁸⁵ Where a court finally concludes that an individual is incompetent to consent to or refuse treatment, the court should either make the medical decision itself, on the basis of the evidence it needs to ascertain incapacity, or should delegate the authority to a guardian¹⁸⁶ acting under close judicial supervision. As *Kaimowitz* indicated, the kind of consent required varies with the procedure to be undertaken.¹⁸⁷ Where surgical, major medical,

arteriosclerosis who voluntarily enter hospitals, who need life saving operations and who do not vehemently oppose such operations at all times, may be deemed incompetent to refuse treatment.

179. See HEW Report, *supra* note 84, at 3.

180. 464 F.2d 772 (D.C. Cir. 1972).

181. Civ. No. 73-19434-AW (Mich. Cir. Ct. July 10, 1973), 42 U.S.L.W. 2063.

182. 70 Misc.2d 944, 335 N.Y.S.2d 461 (Sup. Ct. 1972).

183. See, e.g., *Canterbury*, 464 F.2d at 785.

184. Cf. *Kaimowitz*, Civ. No. 73-19434-AW, at 25.

185. See Harper & James, note 53 *supra*.

186. Cf. *In re Battenow*, 23 N.Y.2d 386, 244 N.E.2d 677, 297 N.Y.S.2d 97 (1968), discussed at notes 171-77 *supra* and accompanying text. The choice of guardians is thus crucial; courts should select individuals on the basis of their demonstrated intent and ability to protect the rights and interests of the patient.

187. *Kaimowitz*, Civ. No. 73-19434-AW, at 22. See note 126 *supra*.

electroshock, radiation, or experimental treatments are proposed, only the court should have the power to authorize the treatment.¹⁸⁸ Finally, a finding of incapacity to consent to or refuse treatment should not be considered presumptive of general civil incapacity, mental illness, or the need for involuntary care.¹⁸⁹ Each of these issues is a distinct question which should be adjudicated by careful consideration of its own applicable standards.

MINORS' CAPACITY TO CONSENT TO HEALTH CARE

Introduction.—In most states, unless an "emergency" existed or the child was emancipated, physicians traditionally had a legal obligation to obtain the consent of the parents or the person standing *in loco parentis* before examining or treating a minor.¹⁹⁰ Minors' own capacity to consent, however, has been recognized for certain medical procedures,¹⁹¹ as restrictive state laws requiring parental consent¹⁹² have been abrogated and the scope of emergency situations has been broadened by legislatures.¹⁹³ Distinct similarities exist between the provisions of some "medical consent" statutes¹⁹⁴ and the common law rule of emancipation,¹⁹⁵

188. See, e.g., N.Y. Mental Hygiene Law § 15.03(B)(4) (McKinney Supp. 1973). See N.Y. Dep't Mental Hygiene, Draft Regulations, Part 27, Quality of Care and Treatment, § 27.2 (1973).

189. Cf. notes 168 & 169 *supra* and accompanying text.

190. The reason for this is that physicians and hospitals fear liability for battery. See Stern, Medical Treatment and the Teenager: The Need for Parental Consent, 7 Clearinghouse Rev. 1 (May 1973) [hereinafter cited as Clearinghouse]. For a thorough discussion of this topic see Pilpel, Minors' Rights to Medical Care, 36 Albany L. Rev. 462 (1972). But see Comment, Medical Care and the Independent Minor, 10 Santa Clara Law. 334 n.3 (Spring 1970), for a collection of cases demonstrating the courts' confusion regarding the necessity for parental consent. One commentator stated that she had

found no reported cases holding a physician civilly liable for furnishing medical services without parental consent where the minor was over the age of 15 and the treatment was rendered with the minor's consent and was for the minor's benefit.

Zuckerman, Abortion and the Constitutional Rights of Minors, A.C.L.U. Reports 4 n.2 (July 1973).

191. Medical procedures usually excepted include diagnosis and treatment of venereal diseases (see, e.g., Alaska Stat. § 09.65.100(a) (1972); Ariz. Rev. Stat. Ann. § 44-132.01 (Supp. 1973)), donation of blood (see, e.g., Iowa Code Ann. § 599.6 (Supp. 1973) (18 years or older)), and treatment of drug related problems (see Clearinghouse, *supra* note 190, at 2 n.9 for collection of statutes permitting treatment of minors for addiction and related problems).

192. The requirement of parental consent may be imposed implicitly or explicitly, but often is mandated by means of statutes defining the age of majority. Clearinghouse, *supra* note 190, at 1 n.2. See, e.g., Wis. Stat. § 990.01(20) (Cum. Supp. 1973) (age of majority is 18 years old); Wyo. Stat. Ann. § 14-1.1 (Supp. 1973) (age of majority is 19).

193. See, e.g., Fla. Stat. Ann. § 458.21 (Supp. 1973); Ill. Ann. Stat. ch. 91, § 18.3 (Smith-Hurd 1973); Pa. Stat. Ann. tit. 35, § 10104 (Supp. 1973).

194. See, e.g., N.Y. Pub. Health Law § 2504(1) (McKinney Supp. 1973) ("Any person who is eighteen years of age or older, or is the parent of a child or has married, may give effective consent for medical, dental, health and hospital services for himself

each including such indices as marriage, judicial decree, act of parent or enlistment in the military service.¹⁹⁶ In a growing number of states, courts have gone even further and gradually have transformed the rule of the "emancipated minor" into the rule of the "mature minor"¹⁹⁷ by refusing in many situations to rigidly apply these technical requirements for emancipation.¹⁹⁸ Certain statutes provide that a minor will be deemed "mature" and able to give valid consent to medical treatment where the procedure is for the benefit of the minor and he can understand its nature and consequences.¹⁹⁹ Although commentators have applauded such legislative innovations, they note that the difficulty in determining the "legal maturity" of minor patients and the inability of physicians to hold them liable for their debts may serve as continuing impediments to the flow of medical services to minors.²⁰⁰

Beyond the inherent difficulties involved in construing "medical consent" statutes, other problems arise from the widespread failure of courts and legislatures to delineate adequately either the scope of minors' rights or the theory upon which the state intervenes on their behalf.²⁰¹

or herself, and the consent of no other person shall be necessary."); Colo. Rev. Stat. Ann. § 41-2-13 (Supp. 1971).

195. See, e.g., *Lawson v. Brown*, 349 F. Supp. 203 (W.D. Va. 1972). The concept of emancipation applies in other contexts beyond consent to medical treatment and is generally delineated by case law in each state. See, e.g., 67 C.J.S. Parent and Child § 86 (1950) and 32 A.L.R.3d 1055 (1970).

196. Some statutes explicitly provide that emancipated minors may consent effectively to medical treatment. See, e.g., Ind. Ann. Stat. § 35-4409 (1969). Other statutes provide that certain circumstances (considerations derived from the case law concerning emancipation) render a minor competent to consent: marriage or marriage and divorce (see, e.g., Ala. Code tit. 34, § 76 (Cum. Supp. 1971); Cal. Civ. Code § 25.6 (West Supp. 1973)); pregnancy or parenthood (see, e.g., Ill. Ann. Stat. ch. 91, § 18.1 (Smith-Hurd 1973); Md. Ann. Code art. 43, § 135 (Supp. 1973)); active duty in the military (see, e.g., Cal. Civ. Code § 25.7 (West Supp. 1973)).

197. See Pilpel & Wechsler, *Birth Control, Teenagers and the Law*, 1 Family Planning Perspective 29, 30 (Spring 1969); Pilpel & Zuckerman, *Abortion and the Rights of Minors*, 23 Case W. Res. L. Rev. 779, 782 (1972).

198. See, e.g., *Schumm v. Schumm*, 122 N.J. Super. 146, 299 A.2d 423 (Super. Ct. Ch. 1973); *Lacey v. Laird*, 166 Ohio St. 12, 139 N.E.2d 25 (1956).

199. See, e.g., Miss. Code Ann. § 41-41-3 (1972): "Any unemancipated minor of sufficient intelligence to understand and appreciate the consequences of the proposed surgical or medical treatment" may effectively consent.

200. See Clearinghouse, *supra* note 190, at 4; *Medical Care and the Independent Minor*, *supra* note 190, at 344-45.

201. See, e.g., *Matter of Comm'r of Social Serv. on behalf of Michael D. v. Bette D.*, 72 Misc. 2d 428, 339 N.Y.S.2d 89 (Family Ct. 1972) which raises but never answers this question:

Is the consent to surgery by a parent or other person standing *in loco parentis* to the child necessary only because the child, by virtue of his infancy lacks the capacity to consent or is consent necessary because the parent has a property interest in the body of his child?

Id. at 430, 339 N.Y.S.2d at 91. The concept of a "proprietary" interest in children is highlighted in cases where parents consent to surgical invasion of one child's body for the purpose of donating an internal organ to another person. This topic, however, is beyond the scope of this article. See 35 A.L.R.3d 692 (1971); Curran, *A Problem*

When the issue of a minor's need for health services emerges and no statutory provision infuses the child with decision-making power, courts must adjudicate complex questions regarding the priority of authority to consent to or refuse treatment. Conflicts have surfaced in litigation in two basic forms. One recent group of cases raises the issue of the state's role as arbiter when disagreements between a parent and a child arise over the advisability of the child's abortion. There is also another category of actions wherein the courts have sought to define the state's role vis à vis the parents as the guardian of the child's best interests when non-emergency medical treatments have been recommended.

Authority to Consent—When Parent and Child Disagree.—Abortion cases have provided a vehicle for examination of broad medical consent statutes which have been construed to allow female minors to obtain and refuse this medical treatment in derogation of parental wishes. Aside from local statutory decisions,²⁰² certain cases have arisen as a result of unanswered questions contained in United States Supreme Court rulings. In particular, *Roe v. Wade*²⁰³ signalled the possibility of a constitutional right to abortion,²⁰⁴ and now has necessitated analysis of the constitutional effect of the incidents of minority.²⁰⁵

While it is difficult to determine whether the opinions highlighted below are indicative of judicial (particularly trial court) tendencies with respect to the general issue of minors' capacity to consent to health care,²⁰⁶ these cases are significant because very few parent-child disputes reach the adjudicative stages. The cases examined suggest that one approach to facilitate courts' determination of the minor's ability to understand the proceedings and to give an informed consent is a "totality of circumstances" test.²⁰⁷ Certain other cases evidence judicial interpretation of the Supreme Court decisions leading to the conclusion that the abortion decision rests solely with the pregnant minor herself.²⁰⁸

of Consent: Kidney Transplantation in Minors, 34 N.Y.U.L. Rev. 891 (1959). See also N.Y. Times, Aug. 31, 1973, at 14, col. 2, which relates an incident in which parents consented to the removal of life-sustaining breathing tubes from their injured son so that his kidney could be removed and prepared for transplanting; and N.Y. Times, Oct. 28, 1973, at 3, col. 4, reporting a state appeals court ruling that a Louisiana law which prevents a minor from donating private property had stopped a retarded teenager from giving one of his kidneys to an ailing sister despite parental consent.

202. See *Ballard v. Anderson*, 4 Cal. 3d 873, 484 P.2d 1345, 95 Cal. Rptr. 1 (1971); *In re Smith*, 16 Md. App. 209, 295 A.2d 238 (1972).

203. 410 U.S. 113 (1973).

204. See note 6 *supra*.

205. See *Coe v. Gerstein*, Civ. No. 72-1842 (S.D. Fla. Aug. 13, 1973), discussed at notes 257-70 *infra* and accompanying text.

206. The difficulty actually stems from the inevitably controversial and unique nature of the abortion decision.

207. See *Matter of P.J.*, 12 Cr. L. Rptr. 2549 (D.C. Super. Ct. Feb. 6, 1973), discussed at notes 247-49 *infra* and accompanying text. See also *People v. Lara*, 67 Cal. 2d 365, 432 P.2d 202, 62 Cal. Rptr. 586 (1967), and cases cited at note 250 *infra*.

208. See *Coe v. Gerstein*, Civ. No. 72-1842 (S.D. Fla. Aug. 13, 1973).

Some states have elected to deal with this consent problem statutorily. At least fourteen states now provide that minors may consent to medical and surgical treatment related to pregnancy.²⁰⁹ Two of these states, however, Hawaii and Missouri, specifically exclude abortion as a type of "pregnancy-related treatment" covered by their statutes.²¹⁰ Virginia has specific provisions in its therapeutic abortion statute requiring parental consent for unmarried minors and spousal approval for married minors.²¹¹

Although eleven states have left for judicial determination the question of whether pregnancy-related treatment includes abortion, only California and Maryland have resolved the issue.²¹² In the 1971 case *Ballard v. Anderson*,²¹³ the California courts reviewed the refusal of a therapeutic abortion committee to consider the application of a twenty year-old, unmarried, indigent minor living at home, for the sole reason that she had not obtained parental consent. The Supreme Court of California vacated the decision of the court of appeals and specifically held that the California medical treatment statute²¹⁴ emancipated unmarried, pregnant minors for the purpose of obtaining therapeutic abortions without parental consent.²¹⁵ In so holding, the court essentially interpreted a consent statute, passed fourteen years before California's therapeutic abortion act, as giving minors the power to consent to a broader class of medical procedures than was legally permissible at the time of that statute's enactment. Since *Ballard*, the United States Supreme Court's

209. Ala. Code tit. 22, §§ 104(15) to 104(22) (Supp. 1971); Cal. Civ. Code § 84.5 (West 1954); Del. Code Ann. tit. 13, § 708 (Supp. 1970); Ga. Code Ann. § 88-2904 (Supp. 1972); Hawaii Rev. Stat. §§ 577A-1 to 577A-2 (Supp. 1972); Kan. Stat. Ann. § 38-123 (Supp. 1972); Ky. Rev. Stat. Ann. § 214.185 (Supp. 1972); Md. Ann. Code art. 43, § 135 (Supp. 1973); Minn. Stat. Ann. § 144.343 (Supp. 1973); Miss. Code Ann. § 41-41-3 (1972); Mo. Stat. Ann. §§ 431.061 to 431.063 (Supp. 1973); N.J. Stat. Ann. § 9:17A-1 (Supp. 1973); Pa. Stat. Ann. tit. 35, § 10103 (Supp. 1973); Va. Code Ann. § 32-137 (Supp. 1973). For a comprehensive table of state legislation relating to treatment of minors as of September, 1971, see Pilpel, *Minors' Rights to Medical Care*, 36 Albany L. Rev. 462, 472 (1972).

210. Hawaii Rev. Stat. § 577A-1 (Supp. 1972); Mo. Stat. Ann. § 431.061(1) (Supp. 1973).

211. Va. Code Ann. § 18.1-62.1(e) (Supp. 1973) (parental consent required for women under 18 and for any woman deemed an infant or incompetent by a court of competent jurisdiction). The validity of this provision may be in doubt, however. See *Coe v. Gerstein*, Civ. No. 72-1842 (S.D. Fla. Aug. 13, 1973) (discussed at notes 257-70 *infra* and accompanying text) striking down a similar Florida statute.

212. See notes 213-16 *infra* (California) and 218-34 *infra* (Maryland) and accompanying text.

213. 4 Cal. 3d 873, 484 P.2d 1345, 95 Cal. Rptr. 1 (1971).

214. Cal. Civ. Code § 34.5 (West 1954), which provides in pertinent part: Notwithstanding any other provision of the law, an unmarried pregnant minor may give consent to the furnishing of hospital, medical and surgical care related to her pregnancy, and such consent shall not be subject to disaffirmance because of minority.

215. 4 Cal. 3d at 884, 484 P.2d at 1353, 95 Cal. Rptr. at 9.

decision in *Roe v. Wade*²¹⁶ has expanded the class of legal abortions even further by validating only those state regulations designed to protect either the fetus at the point of viability or maternal health at the end of the first trimester.²¹⁷ In view of the *Ballard* court's reasoning that minors possess discretion which encompasses the right to obtain a legal abortion, *Roe v. Wade* may well have enlarged the dimensions of minority emancipation in California.

In 1972, the Maryland Court of Special Appeals went one step beyond *Ballard* when it interpreted Maryland's minority consent statute in *In re Smith*.²¹⁸ Cindy Lou Smith, sixteen years of age, unmarried, unemancipated and two months pregnant, appealed a juvenile court order which had been issued pursuant to her mother's petition and which had directed her to submit to medical procedures possibly leading to an abortion.²¹⁹ Affirming that Cindy was a "child in need of supervision,"²²⁰ the appellate court nevertheless reversed the lower court's order requiring the examinations related to her pregnancy.²²¹

Since the status of unemancipated minors was governed generally by common law doctrine which dictated that legally enforceable actions required parental consent, any contrary principles granting minors new rights and independence needed to be expressly provided by statute.²²² In *Smith*, however, the real question facing the court was not the necessity of parental consent, but rather the ability of a minor to act in derogation of her parent's will.²²³

Acknowledging that the right to abortions was purely statutory,²²⁴

216. 410 U.S. 113 (1973).

217. *Id.* at 163-64.

218. 16 Md. App. 209, 215, 295 A.2d 238, 241 (1972).

219. The state's statute permits abortions only under specified conditions, so the court merely had the power to order Cindy to be examined to see if she qualified for the treatment. See note 224 *infra*.

220. *Id.* at 215, 295 A.2d at 241.

221. *Id.* at 226, 295 A.2d at 246.

222. See Md. Ann. Code art. 43, § 135(a) (Supp. 1973), which provides:

(a) A minor shall have the same capacity to consent to medical treatment as an adult if one or more of the following apply: (1) The minor has attained the age of eighteen (18) years. (2) The minor is married or the parent of a child. (3) The minor seeks treatment or advice concerning venereal disease, "pregnancy" or contraception not amounting to sterilization. (4) In the judgment of a physician treating a minor, the obtaining of consent of any other person would result in such delay of treatment as would adversely affect the life or health of the minor. (5) The minor seeks treatment or advice concerning any form of drug abuse as defined in § 2(d) of Article 43B of the Annotated Code . . . (Emphasis added.)

223. 16 Md. App. at ____, 295 A.2d at 245.

224. See *Id.* at ____, 295 A.2d at 244-45. This case was decided before *Roe v. Wade*. See Md. Ann. Code art. 43, §§ 137 to 139 (1971), which enumerate the limited circumstances under which an abortion is available. In fact, it was unclear whether Cindy even could have legitimately obtained an abortion. 16 Md. App. at ____, 295 A.2d at 246.

the court reviewed the Maryland Code abortion provisions, Article 43, sections 137 to 139, which provided in particular in section 138 that no person could be forced to submit to an abortion.²²⁵ By defining the phrase "treatment . . . concerning . . . pregnancy" in Maryland's minors' consent statute²²⁶ to include abortions, the court granted minors the authority of adults for these purposes. This theory thus placed minors within the category of "person(s)" described in section 138 of the abortion statute.²²⁷ The court's finding that the legislative intent was to permit minors to override their parents' wishes has been the subject of some comment.²²⁸ If the philosophy behind the enactment had been "to encourage children not to have unplanned families," as the lower court had indicated,²²⁹ Cindy's capacity to oppose her parents would not have been within legislative contemplation. Thus the court could have decided that the order for an abortion examination would have been appropriate. The appellate court, however, held that the legislature's design was to emancipate the minor with respect to any medical care encompassed by the statute as construed by the court, and therefore Cindy's decision was correctly controlling.²³⁰

Illustrative of the theoretical difficulties in these cases are the contrasting approaches to the problem adopted by the *Smith* trial and appellate courts, which each addressed itself to different fundamental issues. The lower court emphasized the practical hardships which would face Cindy, her parents and the unborn child.²³¹ The appellate court instead concerned itself with the issue of who should have the power to consent to, or refuse, the medical treatment.²³² While this Maryland decision may augur well for the rights of minors to consent to abortions in the other nine states similarly situated,²³³ such a forecast may be a little optimistic because the Maryland statute²³⁴ is exemplary in its extension of minors' rights.

225. Md. Ann. Code art. 43, §§ 138(a) and 138(c) (1971).

226. Md. Ann. Code art. 43, § 135(a)(3) (Supp. 1973). See note 222 *supra*.

227. 16 Md. App. at 225, 295 A.2d at 246. See note 225 *supra* and accompanying text.

228. See 7 Suffolk U.L. Rev. 1157, 1162-63 (1973).

229. 16 Md. App. at 217, 295 A.2d at 242.

230. *Id.* at 225, 295 A.2d at 246.

231. *Id.* at ____, 295 A.2d at 244. The trial judge noted the hardship a baby was likely to impose on a social agency or the grandparents since the young parents were bound to have financial and other problems.

232. See *id.* at ____, 295 A.2d at 245-46. For recently promulgated federal guidelines dealing with sterilization procedures for persons under 21 and legally incapable of consenting, see Proposed H.E.W. Reg. § 50.301-305, 38 Fed. Reg. 26460 (Sept. 21, 1973).

233. See notes 209-12 *supra* and accompanying text.

234. Md. Ann. Code art. 43, § 135(a) (Supp. 1973). See also American Academy of Pediatrics, Committee on Youth, A Model Act Providing for Consent of Minors for Health Services, 24 Juvenile Justice 60 (1973).

Smith and *Ballard* thus demonstrate a technique in statutory construction. To protect minors' ability to control the procedures to which their bodies would be subject, these courts construed the provisions relating to pregnancy in the relevant medical consent statutes as authorizing female minors to consent to their own abortions. In each of these cases, the scope of this authority was governed by the parameters of legal abortions as set out in the corresponding state therapeutic abortion statute. This technique now may be employed on a broader scale since the Supreme Court's decisions in *Roe v. Wade*²³⁵ and *Doe v. Bolton*²³⁶ constitute a nation-wide and constitutionally-founded expansion of the category of legal abortions.²³⁷ At the very least, the *Ballard/Smith* reasoning now will apply in any state with a medical consent statute which the courts have interpreted as granting minors authority over treatments associated with pregnancy,²³⁸ regardless of that state's pre-existing abortion laws.

There may also be a constitutional basis for the principle that minors have the right to consent to (or refuse) abortions even in states without specific medical consent statutes. While the Court specifically refused to consider the validity of statutes requiring parental or paternal consent,²³⁹ Justice Blackmun located a right of privacy in the fourteenth amendment's concept of personal liberty.²⁴⁰ The Court held that a state had the power to impinge upon the woman's fundamental right to control what is done to her body only when the state's interest was sufficiently compelling and regulations of the procedures were narrowly drawn.²⁴¹ The only state interests deemed adequately compelling were the pregnant-woman's health at the end of the first trimester and pre-natal life at the end of the second trimester. Therefore, unless the mere status of minority serves to limit a woman's fourteenth amendment rights, or the state is found to have some other compelling interest satisfied by granting the parents authority superior to that of the pregnant minor to decide

235. 410 U.S. 113 (1973).

236. 410 U.S. 179 (1973).

237. *Roe* prohibited all state regulation of abortion during the first trimester. 410 U.S. at 163. See also text accompanying notes 216 & 217 *supra*.

238. See statutes cited in note 209 *supra*. Query whether the medical consent statutes in Hawaii and Missouri (see note 210 *supra*) are still valid.

239. *Roe v. Wade*, 410 U.S. at 165 n.67.

240. *Id.* at 152-53.

241. *Id.* at 162-63. See generally *Developments in the Law—Equal Protection*, 82 Harv. L. Rev. 1065 (1969). Essentially the doctrine provides that statutory classifications which differentiate between groups of people otherwise similarly situated by reliance upon "suspect" criteria (e.g., race, see *Korematsu v. United States*, 323 U.S. 214, 216 (1964)) or by affecting a group of persons' "fundamental interests" (e.g., procreation, see *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942)) will be held unconstitutional as a denial of equal protection unless justified by a "compelling" state interest.

whether she should bear a child, any state regulation beyond that approved in *Roe* should be held unconstitutional.²⁴²

The principle that minors are full-fledged citizens within the meaning of the fourteenth amendment and the Bill of Rights was affirmed by the Supreme Court's decision in *In re Gault*.²⁴³ In addition, there are a variety of other situations in which the Court has extended basic constitutional guarantees to minors.²⁴⁴

The Supreme Court, however, has never directly confronted the issue of a minor's rights vis à vis his parents where the two conflict.²⁴⁵ This dearth of case law is due at least in part, to an express or implied unity of interest between the parent and child. Recently, however, the validity of this theoretical merger of interests has been disputed in several contexts.²⁴⁶

One lower court case, *Matter of P.J.*,²⁴⁷ clearly acknowledged that the mere status of minority should not render a person incompetent to make an abortion decision. The court ruled that a seventeen year-old be permitted to have an abortion despite the objections of her mother, who had cared for her daughter's first child. The court not only looked to the pregnant minor's own ability to give an informed consent, but also noted the disparity between her religious beliefs and those of her parents:

[T]he court has found that although a juvenile, and despite her age, Respondent's status was one of quasi-emancipation; her degree of maturity and knowledge was such that she fully understood the nature of the operation, how the operation is performed, and effects of such an operation; and that having an abortion does not violate any of her religious beliefs, which are distinguished from those of her parents.²⁴⁸

242. See *Coe v. Gerstein*, Civ. No. 72-1842 (S.D. Fla. Aug. 13, 1973), discussed at notes 257-70 *infra* and accompanying text.

243. 387 U.S. 1 (1969). The *Gault* court specifically rejected the idea that any alleged societal benefits resulting from informal juvenile court procedures constituted a valid basis for depriving a minor of the right to procedural due process, and stated that "neither the Fourteenth Amendment or the Bill of Rights is for adults alone." *Id.* at 13.

244. See, e.g., *In re Winship*, 397 U.S. 358 (1970) (proof beyond a reasonable doubt standard to be applied in juvenile court); *Tinker v. Des Moines School Dist.*, 393 U.S. 503 (1969) (freedom of speech for students); *Board of Educ. v. Barnette*, 319 U.S. 624 (1943) (compulsory pledge of allegiance declared unconstitutional).

245. For a forceful argument in support of the theory that a child should be the constitutional equal of an adult, see Kaimowitz, *Legal Emancipation of Minors in Michigan*, 19 *Wayne L. Rev.* 23 (1972).

246. See *Wisconsin v. Yoder*, 406 U.S. 205, 241 (1972) (Douglas, J., dissenting in part). The majority held they did not need to reach the issue of a possible conflict between parent and child. *Id.* at 231. Cf. *Rowan v. United States Post Office Dep't*, 397 U.S. 728, 730 n.1 (1970).

247. 12 Cr. L. Rptr. 2549 (D.C. Super. Ct. Feb. 6, 1973).

248. *Id.*

The court's emphasis on a totality of factors, rather than age alone,²⁴⁹ was an adaptation of a recognized approach for determining a given minor's maturity and his or her competence to be treated as an adult. This method traditionally has been used in cases concerning the effectiveness of waivers of minors' constitutional rights.²⁵⁰ There is therefore a suggestion that some courts have afforded broad constitutional protections to minors; in the proper instances courts will not permit parental waiver of minor's rights without a factual determination that the child is incompetent to rationally comprehend the situation. Thus, under this line of authority, if a mature minor is competent to waive certain constitutional rights, logically he must possess the capacity necessary to assert them.

If it is assumed for the purposes of this analysis that the mere status of minority does not have a detrimental effect on a person's constitutional rights, it follows that a parental consent requirement will pass constitutional muster only if it serves a compelling state interest. The two justifications most frequently advanced are the need to protect the minor from her own improvidence and the importance of preserving the family unit by sustaining the primacy of parental control.²⁵¹

The first justification is immediately suspect in any state where the legislature has lowered or abolished the age of consent for any medical treatments since these states theoretically have conceded already that minors are capable of making informed decisions regarding their own health. Moreover, if a woman is pregnant it is too late to "save" her from improvident sexual activity. To deny her a desired abortion is to suggest that she is not mature enough to make that decision, but is mature enough to give birth to, and care for, a child.²⁵²

Finally even assuming that the state's interest in protecting minors

249. See Stern, *Furnishing Information and Medical Treatment to Minors for Protection, Termination and Treatment of Pregnancy*, 5 *Clearinghouse Rev.* 131, 153 (July 1971).

250. See, e.g., *People v. Lara*, 67 Cal. 2d 365, 432 P.2d 202, 62 Cal. Rptr. 586 (1967), declaring that the validity of a minor's confession made without the presence of counsel or other responsible adult "depend[ed] not on his age alone, but on a combination of that factor with other circumstances such as his intelligence, education, and ability to comprehend the meaning and the effect of his statement." *Id.* at 383, 432 P.2d at 215, 62 Cal. Rptr. at 599. See also *McBride v. Jacobs*, 247 F.2d 595 (D.C. Cir. 1957); *Shioutakon v. District of Columbia*, 236 F.2d 666 (D.C. Cir. 1956), holding that parental waiver of a minor's rights will be effective only where the minor is incapable of making a waiver and the interests of parent and child are not adverse.

251. Pilpel and Zuckerman, *Abortion and the Rights of Minors*, 23 *Case W. Res. L. Rev.* 779, 799-800 (1972).

252. In addition there is the possibility that denied a medically safe, legal abortion, a young woman would seek the services of an illegal and unsafe abortionist rather than consult her parents.

from their own improvidence is deemed compelling, the state cannot sustain a restriction on constitutionally protected activity unless the government has chosen a relatively unburdensome mode of furthering that interest.²⁵³ Any consent statute isolating all women below a certain age sweeps too broadly because it fails to take into account the truly relevant factors—the emotional maturity and intellectual capacity of a female minor—of giving an informed consent.²⁵⁴ Anyway, a statutory presumption that age has its correlate in maturity is not only factually incorrect, but under recent Supreme Court decisions would raise serious due process questions.²⁵⁵

The second justification offered might be that requiring parental consent fosters parental control and thereby sustains the family unit. Referring once again to numerous medical consent statutes, we find legislatures often have determined that parental control is of secondary importance where a minor's health is at stake. Furthermore, in many cases, a minor's pregnancy is a de facto indication of a pre-existing failure of parental control, which can hardly be remedied by a parental consent statute. Moreover to assert this justification after the fact and force these women to bear unwanted children is merely cruel and possibly unconstitutional punishment of unlucky girls for illicit intercourse.²⁵⁶

Portions of the constitutional analysis stemming from *Roe v. Wade* were employed recently by the United States District Court for the Southern District of Florida in *Coe v. Gerstein*.²⁵⁷ The court struck down Florida's "spousal and parental consent" requirement²⁵⁸ on behalf of two

253. See, e.g., *Dunn v. Blumstein*, 405 U.S. 330, 343 (1972) (Marshall, J.).

254. But see note 199 *supra* and accompanying text. See also Stern, *supra* note 249, at 152 n.14.

255. See *Vlandis v. Kline*, 412 U.S. 441 (1973); *Stanley v. Illinois*, 405 U.S. 645 (1972); *Bell v. Burson*, 402 U.S. 535 (1971); *Pilpel, Minors' Rights to Medical Care*, 36 Albany L. Rev. 462, 464 (1972).

256. See *Eisenstadt v. Baird*, 405 U.S. 438 (1972), rejecting the argument that the Massachusetts birth control statute which prohibited the prescription of contraceptives to unmarried persons aided enforcement of its anti-fornication statute. Cf. *State v. Baird*, 50 N.J. 376, 383, 235 A.2d 673, 677 (1967), where Chief Judge Weintraub, concurring, stated that "to prescribe . . . [an unwanted pregnancy] . . . as a punishment for illicit intercourse would be a monstrous thing." But see *Doc v. Planned Parenthood Ass'n of Utah*, 29 Utah 2d 356, 510 P.2d 75 (1973), upholding a statute which prohibited minors from obtaining contraceptive services without parental consent.

257. Civ. No. 72-1842 (S.D. Fla. Aug. 13, 1973).

258. Fla. Stat. Ann. § 458.22(3) (Supp. 1973):

One of the following shall be obtained by the physician prior to terminating a pregnancy:

(a) The written request of the pregnant woman and, if she is married, the written consent of her husband, unless the husband is voluntarily living apart from the wife, or

(b) If the pregnant woman is under eighteen years of age and unmarried, in addition to her written request, the written consent of a parent, custodian or legal guardian must be obtained, or

females each pregnant for less than three months. One of the plaintiffs, Patricia Noe, was an unmarried minor unable to obtain parental consent for a therapeutic abortion.²⁵⁹

The court noted at the outset that *Roe v. Wade* and *Doe v. Bolton* dealt specifically with the state's interest in the protection of maternal and fetal health and did not address the interests of third parties, such as the father or husband and the parents.²⁶⁰ The court reasoned that the state was proscribed from imposing any regulations (even those made on behalf of the fetus' father or grandparents) which had as their purposes the interests enumerated in *Roe*, except at times and in manners therein provided.²⁶¹ However, if Florida had demonstrated that the third party interests, which were to be protected by its statute, attached at the time of conception and fell completely outside the categories of protection of maternal health and potential life, the court would have conceded that *Roe* was not controlling.²⁶²

The court recognized that the interest of the husband or parent in the pregnant wife or daughter and the fetus which she carries is qualitatively different from the interest which the state may constitutionally assert.²⁶³ Nevertheless, even if such compelling parental and paternal interests existed from the moment of conception, the court held that the statute was fatally defective:

. . . [I]t is apparent that not *all* paternal or parental interests fall outside the categories of protection of maternal health and potential life. . . . The failure of the Florida "spousal or parental consent requirement" is that it gives to husbands and parents the authority to withhold consent for abortions for any reason or no reason at all.²⁶⁴

The court concluded that since the state cannot interfere with a woman's right of privacy in the first trimester to protect her health, or before viability to protect the fetus, it cannot delegate to third parties an authority it does not possess.²⁶⁵

Although the decision reaches an admirable result and is in keeping with recent trends in the area of juvenile rights, its reasoning may be

(c) Notwithstanding paragraphs (a) and (b) of this subsection, a physician may terminate a pregnancy provided he has obtained at least one corroborative medical opinion attesting to the medical necessity for emergency medical procedures and to the fact that to a reasonable degree of medical certainty the continuation of the pregnancy would threaten the life of the pregnant woman.

259. Civ. No. 72-1842, at 2. The other plaintiffs were several physicians practicing family medicine and Nancy Coe, a pregnant married woman unable to obtain her husband's consent to an abortion. *Id.*

260. *Id.* at 3 & n.4.

261. *Id.* at 4.

262. *Id.*

263. *Id.* at 4-5.

264. *Id.* at 5.

265. *Id.* at 6.

vulnerable to some critical comment. The court, for instance, stated categorically that "a pregnant woman under 18 years of age cannot, under the law, be distinguished from one over 18 years of age in reference to 'fundamental,' 'personal' constitutional rights,"²⁶⁶ but failed to consider that the Supreme Court's reasoning in *Roe* might lead to a broader right for minors than adults. For instance, application of the *Roe* concept of "trimester" time periods might be inappropriate for minors. For an older woman, the dangers of carrying a baby to term may be greater than having an abortion within the first trimester. Since the dangers of pregnancy and childbirth increase as age decreases to a certain point,²⁶⁷ abortion might be a comparatively safer procedure for young minors even beyond the parameters of the first trimester.

An interest mentioned by the court which admits of unique application to minors is that of the preservation and primacy of the family unit. Although reasons previously mentioned²⁶⁸ indicate the shortcomings of this approach, the court does little more than imply that this justification may be insufficient to sustain the statute merely because it is reasonably related to protection of maternal health and potential life. The court's opinion, therefore, could have been strengthened had it distinguished the state's interest in regulating the abortions of minors from that in regulating adults.

A thorough analysis of permissible third party interests would entail a consideration of those private interests whose existence is not dependent upon a grant of authority from the state,²⁶⁹ as well as those which the state may create through a delegation of its power. The court does not address the enforceability of this first class of interests, probably because its scrutiny is focused on the Florida statute. With respect to the latter class, the court seems to recognize the possibility of state regulation which would allow consent to be withheld within the first trimester for reasons other than protection of maternal health and potential life, if the existence of such reasons could be demonstrated. Although this might seem to open the door for amended regulations, the difficulties presented by such an alternative are well documented in a footnote by the court:

Because of the practical problems involved in drafting or enforcing a statute which would exclude interests related to maternal health in the first trimester, we are inclined to agree with Mr. Justice Rehnquist (dissenting) that

266. *Id.*

267. See Guttmacher, *The Genesis of Liberalized Abortion*, 23 *Case W. Res. L. Rev.* 756, 768 (1972).

268. See note 256 *supra* and accompanying text.

269. *Civ. No. 72-1842*, at 6. See text accompanying note 265 *supra*. Cf. *Evans v. Newton*, 382 U.S. 296 (1966); *Shelley v. Kraemer*, 334 U.S. 1 (1948).

as a practical matter, "a state may impose virtually no restrictions on the performance of abortions during the first trimester of pregnancy." *Roe v. Wade*, 93 S. Ct. at 736.²⁷⁰

Although the court reaches a laudable and timely result while confronting a number of significant and difficult issues, its opinion would have had even greater ramifications for minors' rights had it more carefully applied *Roe's* reasoning and more explicitly responded to the possibility of third party interests unique to a minor woman.

Authority to Consent—When Parent and State Disagree.—The juvenile courts, the primary forum for the determination of minors' rights, traditionally possessed only weak common law bases upon which to rest their jurisdiction when they sought to order medical treatment for infants over parental objections.²⁷¹ In an effort to alleviate this problem, states have enacted civil statutes, based on their police power, granting the courts authority to deprive a parent of custody where an infant is found to be "neglected," "dependent," or in need of "necessaries."²⁷² Thus, the question of a state's privilege to order corrective or preventative non-emergency medical care for infant citizens has become largely one of statutory interpretation.²⁷³

270. Civ. No. 72-1842, at 6 n.6.

271. Courts have used the theories of *parens patriae* (see, e.g., *Johnson v. State*, 18 N.J. 422, 430-31, 114 A.2d 1, 5 (1955); Note, *Compulsory Medical Treatment and the Free Exercise of Religion*, 42 Ind. L.J. 386, 390-91 n.30 (1967); 64 Mich. L. Rev. 554, 555 n.5 (1966)), the provision of "necessaries" (see, e.g., *Pickering v. Gunning, Palmer*, 528, 81 Eng. Rep. 1204 (1629); Council of Judges, National Council on Crime and Delinquency, *Guides to the Judge in Medical Orders Affecting Children*, 14 Crime & Delinq. 109-10 (1968); *Justice v. State*, 116 Ga. 605, 606, 42 S.E. 1013, 1014 (1902) (holding that necessary sustenance does not include medical care)) or an affirmative duty to protect life (see, e.g., *Application of President and Directors of Georgetown College*, 331 F.2d 1000, 1008 (D.C. Cir.), cert. denied, 377 U.S. 978 (1964); *United States v. George*, 239 F. Supp. 752 (D. Conn. 1965); *Raleigh Fitkin-Paul Morgan Mem. Hosp. v. Anderson*, 42 N.J. 421, 201 A.2d 537, cert. denied, 377 U.S. 985 (1964); *Hoener v. Bertinato*, 67 N.J. Super. 517, 171 A.2d 140 (Juv. & Dom. Rel. Ct. 1961). See also *John F. Kennedy Mem. Hosp. v. Heston*, 58 N.J. 576, 279 A.2d 670 (1971). But see *In re Estate of Brooks*, 32 Ill. 2d 361, 205 N.E.2d 435 (1965); *Erickson v. Dilgard*, 44 Misc. 2d 27, 252 N.Y.S.2d 705 (Sup. Ct. 1962)). Some states also had enacted penal laws to compel parents to provide adequate medical care, but these provisions contain the inherent deficiency that often they were applicable only after irreparable harm had befallen the child. See *People v. Pierson*, 176 N.Y. 201, 60 N.E. 243 (1903); *Craig v. State*, 220 Md. 590, 155 A.2d 684 (1959); *Mitchell v. Davis*, 205 S.W.2d 812 (Tex. Civ. App. 1947). See generally Note, *Court Ordered Non-Emergency Medical Care for Infants*, 18 Clev.-Mar. L. Rev. 296 (1969); 41 U. Cin. L. Rev. 961, 963 (1972).

272. See, e.g., Cal. Welf. & Inst'ns Code § 600 (West 1972); Conn. Gen. Stat. Rev. § 17-59 (Supp. 1973); Md. Ann. Code art. 26, § 70-1(j) (Supp. 1973); Mo. Rev. Stat. § 211.031 (1959); N.J. Rev. Stat. § 2A:4-34 (1951); N.D. Cent. Code § 27-20-02 (1960); Ohio Rev. Code Ann. § 2151.04 (Page 1968); Wash. Rev. Code Ann. § 13.04.010(12) (1962).

273. The traditional procedure used for obtaining such medical orders involves a finding of neglect which arguably stigmatizes parents as unfit to care for their child.

The New York family court jurisdiction was contested in *Matter of Sampson*,²⁷⁴ a case involving a fifteen year-old boy, Kevin Sampson, who was victim of an extensive neurofibromatosis, or Von Recklinghausen's disease, which manifested itself in the massive deformity of his face and neck. The Commissioner of Health of Ulster County brought a proceeding pursuant to Article 10 of the Family Court Act²⁷⁵ charging the child's mother, Ms. Sampson, with neglect because she had objected to blood transfusions necessary for safe performance of corrective surgery on the child.²⁷⁶ The family court held that it possessed the jurisdictional (both statutory²⁷⁷ and constitutional²⁷⁸) authority to protect the child's welfare by ordering the blood transfusions,²⁷⁹ despite Ms. Sampson's religious²⁸⁰ and medical²⁸¹ objections and the physicians' counsel that surgical risk would decrease with age.²⁸² The court based its conclusion on the serious psychological impairment which might result from such conspicuous

Santos v. Goldstein, 16 App. Div. 2d 755, 227 N.Y.S.2d 450, motion for leave to appeal dismissed, 12 N.Y.2d 672, 185 N.E.2d 904, 233 N.Y.S.2d 465 (1962), emphasized that a mere court order for medical treatment did not indicate the parents were unfit or had neglected their child in the traditional sense. Accord, *Matter of Sampson*, 65 Misc. 2d 658, 676, 317 N.Y.S.2d 641, 658 (Family Ct. 1970), aff'd, 37 App. Div. 2d 668, 323 N.Y.S.2d 253 (1971), aff'd per curiam, 29 N.Y.2d 900, 278 N.E.2d 918, 328 N.Y.S.2d 686 (1972). See notes 274-303 *infra* and accompanying text. One proposal recommends that such statutes provide for emergency medical procedure entirely divorced from any concept of "neglect." Council of Judges, National Council on Crime and Delinquency, *Guides to the Judge in Medical Orders Affecting Children*, 14 *Crime & Delinq.* 109, 117 (1968).

274. 65 Misc. 2d 658, 317 N.Y.S.2d 641 (Family Ct. 1970), aff'd, 37 App. Div. 2d 668, 323 N.Y.S.2d 253 (1971), aff'd per curiam, 29 N.Y.2d 900, 278 N.E.2d 918, 328 N.Y.S.2d 686 (1972).

275. See note 277 *infra*.

276. 65 Misc. 2d at 658, 661, 317 N.Y.S.2d at 643, 645.

277. *Id.* at 663-64, 317 N.Y.S.2d at 647-48. See N.Y. Const. art. 6, § 13(b); N.Y. Family Ct. Act §§ 115, 115(b), 232(a), 232(b), 232(c), 1011, 1012, 1013 (McKinney Supp. 1973).

278. 65 Misc. 2d at 665-69, 317 N.Y.S.2d at 649-52. See U.S. Const. amend. I; N.Y. Const. art. I, § 3.

279. 65 Misc. 2d at 671, 676, 317 N.Y.S.2d at 654, 658. The court believed the state had a paramount duty to insure Kevin's "right to live and grow up without disfigurement." *Id.* at 669, 25 N.Y.S.2d at 652.

280. Jehovah's Witnesses hold as a cardinal principle of their faith that the law of God explicitly forbids the eating or ingestion of blood into the body by any means whatever, including modern surgical procedures for the transfusion of blood. Watchtower Bible and Tract Society, *Blood, Medicine and the Law of God* (1961); *State v. Perricone*, 37 N.J. 463, 181 A.2d 751 (1962), cited in 65 Misc. 2d at 662, 317 N.Y.S.2d at 646.

281. The court identified several potential complications: mismatching of incompatible blood types; circulatory overload or air embolism caused by inept procedures; transmission of diseases such as syphilis, malaria and hepatitis from blood obtained through commercial blood banks. 65 Misc. 2d at 662, 317 N.Y.S.2d at 646.

282. The bigger one grows physically, the smaller the blood loss will be proportional to the total blood supply. *Id.* at 672, 317 N.Y.S.2d at 655.

deformity,²⁸³ and, indeed, had already been reflected in Kevin's "low self concept."²⁸⁴

Initially addressing itself to Ms. Sampson's religious objections, the court contrasted the absolute right to believe as one chooses, with the limited right to act on those beliefs where the public health or welfare is concerned.²⁸⁵ The cases cited in the decision, however, represented only debatable precedent for the court's thesis that the state's power to order blood transfusions overrides religious objections since the earlier cases had specifically involved life-saving treatments.²⁸⁶

The court next weighed the potential benefit from such an operation against the risk involved. Citing *Matter of Rotkowitz*²⁸⁷ for the proposition that the child's life need not be endangered to justify judicial interference, the court found that more than adequate potential benefit existed to outweigh the inherent hazards of surgery.²⁸⁸ Here again, however, this precedent was weak support for the *Sampson* decision since the operation in *Rotkowitz* was far less serious than that in *Sampson* and other facts rendered the cases distinguishable. Moreover, the *Rotkowitz* court itself had stretched the holding of the seminal New York opinion, *Matter of Vasko*.²⁸⁹ *Vasko*, unlike either *Rotkowitz* or *Sampson* concerned a malady which if uncorrected, would probably have resulted in death.²⁹⁰

The only other precedent for the New York court was the dissenting

283. Although during the trial, medical testimony indicated no evidence of thinking disorder, no outstanding personality aberration, and no immediate threat to his sight or hearing (id. at 659-60, 317 N.Y.S.2d at 643-44), Kevin did remain virtually illiterate because he had been exempted from school since age nine by reason of his facial disfigurement.

284. Id. at 660, 317 N.Y.S.2d at 644.

285. *Prince v. Massachusetts*, 321 U.S. 158 (1944); *Cantwell v. Connecticut*, 310 U.S. 296 (1940); *Davis v. Beason*, 133 U.S. 333 (1890); *Reynolds v. United States*, 98 U.S. 145 (1878).

286. See *People ex rel. Wallace v. Labrenz*, 411 Ill. 618, 104 N.E.2d 769, cert. denied, 344 U.S. 824 (1952); *Morrison v. State*, 252 S.W.2d 97 (Mo. Ct. App. 1952); *Raleigh Fitkin-Paul Morgan Mem. Hosp. v. Anderson*, 42 N.J. 421, 201 A.2d 537, cert. denied, 377 U.S. 985 (1964); *State v. Perricone*, 37 N.J. 463, 181 A.2d 751 (1962); *Hocner v. Bertinato*, 67 N.J. Super. 517, 171 A.2d 14 (Juv. & Dom. Rel. Ct. 1961); *Santos v. Goldstein*, 16 App. Div. 2d 766, 227 N.Y.S.2d 450, motion for leave to appeal dismissed, 12 N.Y.2d 672, 185 N.E.2d 904, 233 N.Y.S.2d 465 (1962); *In re Clark*, 21 Ohio Op. 2d 86, 185 N.E.2d 128, 90 Ohio L. Abs. 21 (C.P. 1962).

287. 175 Misc. 948, 25 N.Y.S.2d 624 (Dom. Rel. Ct. 1941). The *Rothowitz* court ordered surgery to stabilize a child's right foot, thereby preventing aggravation and extension of a deformity. The operation, however, was not serious, the child's mother favored the treatment and the father's objections were not religious. Id. at 951, 25 N.Y.S.2d at 627.

288. 65 Misc. 2d at 669-70, 674-75, 317 N.Y.S.2d at 653-54, 657-58.

289. 238 App. Div. 128, 263 N.Y.S. 552 (1933).

290. The child suffered from a malignant growth of the eye. Id. at 130-31, 263 N.Y.S. at 555.

opinion by Judge Stanley Fuld in *Matter of Seiferth*,²⁹¹ a case in which the court of appeals reversed a lower court order for corrective surgery. In attempting to distinguish a case closely analogous on its facts, the *Sampson* court argued that its powers had been expanded by a new section of the Family Court Act,²⁹² giving the family court jurisdiction to order certain care or treatment for physically handicapped children. In addition, the court reasoned that the legislative intent of a recent revision of Article 10 of the Family Court Act²⁹³ conferred upon the court the "broadest power and discretion" to deal with abused and neglected children.²⁹⁴ The *Sampson* court, however, overlooked the fact that the Children's Court Act, in force when *Seiferth* was decided, had given that court the undisputed power to order "necessary" surgery for neglected children.²⁹⁵

The New York Court of Appeals affirmed the *Sampson* ruling and endorsed the Family Court's assumption of broad authority and use of discretion²⁹⁶ in rejecting parents' religious objections. Relying upon a decision²⁹⁷ construing a Washington state statute,²⁹⁸ the New York appellate court followed the trial judge's lead by also ignoring the distinction between life-saving treatments²⁹⁹ and the less extreme procedures at bar or in *Rothkowitz*.

It is well settled that a person's right to practice religion freely does not include the liberty to expose the community or his child to communicable disease.³⁰⁰ Similarly, where a child's life is imperiled by his parents' refusal to provide medical care, courts uniformly have been

291. 309 N.Y. 80, 86, 127 N.E.2d 820, 823 (1955). The court of appeals found that a congenital hair lip and cleft palate, causing disfigurement, a marked speech defect and emotional and psychological sensitivity, did not give rise to such an emergent and serious condition as would threaten the child's life or health.

292. "Whenever a child within the jurisdiction of the court appears to the court to be in need of medical, surgical, therapeutic, or hospital care or treatment, a suitable order may be made therefore." N.Y. Family Ct. Act § 232(b) (McKinney Supp. 1973). The statute had been enacted after the *Seiferth* decision.

293. N.Y. Family Ct. Act §§ 1011-72 (McKinney Supp. 1973).

294. 65 Misc. 2d at 671, 317 N.Y.S.2d at 654.

295. "[N]eglected child' shall mean a child . . . whose parents, guardian or custodian neglect and refuse, when able to do so, to provide necessary medical, surgical, institutional or hospital care for such child." Law of April 10, 1922, ch. 547, § 2(4), [1922] N.Y. Children's Ct. Act (repealed 1962).

296. *Seiferth* was held to have "impliedly or expressly recognized the court's power to direct surgery even in the absence of risk to the physical health or life of the subject or to the public." 29 N.Y.2d 900, 901, 278 N.E.2d 918, 919, 328 N.Y.S.2d 686, 687 (1972).

297. *Jehovah's Witnesses in the State of Washington v. King County Hosp.*, 278 F. Supp. 488 (W.D. Wash. 1967), aff'd per curiam, 390 U.S. 598 (1968). This court overruled a Jehovah's Witnesses' objections to a statute which empowered a court to order medical care for children found "grossly and willfully neglected as to medical care necessary for well being."

298. Wash. Rev. Code Ann. §§ 13.04.010 (1962), 13.04.095 (Supp. 1972).

299. See 278 F. Supp. at 503 n.10 (blood transfusions).

300. See, e.g., cases cited in note 305 infra.

willing to order appropriate relief.³⁰¹ *Sampson*, however, represents an expansion of judicial power which previously had been hinted at almost exclusively by other New York cases.³⁰² Although the initial response to the *Sampson* opinion is one of relief that aid will be granted a boy who, due to a religious tenet embraced by his parents, might have been forced to endure a massive physical deformity throughout his life, the court's intervention has other theoretical ramifications. Essentially, it signals an anomalous return to paternalism or "best interests" adjudication,³⁰³ contrary to the general trend demonstrated by this article.

In express contrast to the New York approach, the Supreme Court of Pennsylvania, in *In re Green*,³⁰⁴ recently held that a mother's religious objections to medical treatment for her son whose life was not in immediate danger should prevail over the state's interests in the child.³⁰⁵ Ricky Ricardo Green, sixteen years old, was a two-time victim of polio attacks which had resulted in obesity and 94 per cent curvature of the spine and prevented him from walking or standing.³⁰⁶ Although remedial surgery had been recommended, Ms. Green, a Jehovah's Witness, had refused to consent to the treatment because of her religious objections to the necessary blood transfusions. While the Pennsylvania court acknowledged the Commonwealth's position that the neglect statutes³⁰⁷

301. See, e.g., *Jehovah's Witnesses in the State of Washington v. King County Hosp.*, 278 F. Supp. 488 (W.D. Wash. 1967), *aff'd per curiam*, 390 U.S. 598 (1968); *Brooklyn Hosp. v. Torres*, 45 Misc. 2d 914, 258 N.Y.S.2d 621 (Sup. Ct. 1965); *Matter of Vasko*, 238 App. Div. 128, 263 N.Y.S. 552 (1933); cases cited in *In re Green*, 448 Pa. 338, ___, 292 A.2d 387, 390 (1972).

302. See, e.g., *Matter of Rotkowitz*, 175 Misc. 948, 25 N.Y.S.2d 624 (Dom. Rel. Ct. 1941). Cf. *In re Karwath*, ___ Iowa ___, 199 N.W.2d 147 (1972); *In the Matter of the Comm'r of Social Serv. on behalf of Michael D. v. Bette D.*, 72 Misc. 2d 428, 339 N.Y.S.2d 89 (Family Ct. 1972); *In re Carstairs*, 115 N.Y.S.2d 314 (Dom. Rel. Ct. 1952); *In re Weintraub*, 166 Pa. Super 342, 71 A.2d 823 (1950).

303. See especially 65 Misc. 2d at 675, 317 N.Y.S.2d at 657-58, where the court explicitly grants all discretion to the surgeons without reserving to the patient or his representative any power or right of informed consent. Compare, e.g., *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972), and other cases discussed in Part I of this article *supra*.

304. 448 Pa. 338, 292 A.2d 387 (1972).

305. 448 Pa. at ___, 292 A.2d at 392. One legitimate state interest exists even if the child's life is not imperiled if his condition threatens society in a manner distinct from its effect on him. See cases involving court ordered vaccinations, e.g., *Zucht v. King*, 260 U.S. 174 (1922); *Jacobson v. Massachusetts*, 197 U.S. 11 (1905); *Mannis v. State*, 240 Ark. 42, 398 S.W.2d 206, cert. denied, 384 U.S. 972 (1966); *Cude v. State*, 237 Ark. 927, 377 S.W.2d 816 (1964); *Wright v. DeWitt School Dist.*, 238 Ark. 906, 385 S.W.2d 644 (1965); *McCartney v. Austin*, 57 Misc. 2d 525, 293 N.Y.S.2d 188 (Sup. Ct. 1968), *aff'd*, 31 App. Div. 2d 370, 298 N.Y.S.2d 26 (1969). See also Comment, 27 Ark. L. Rev. 151, 153 (1973).

306. 448 Pa. at ___, 292 A.2d at 388.

307. A "neglected child" is "[a] child whose parent . . . neglects or refuses to provide proper or necessary . . . medical or surgical care" and may be committed "to the care, guidance and control of some reputable citizen of good moral character . . ."

could be construed to convey authority to a trial court to order medical treatment,³⁰⁸ it held in favor of the child's mother because the free exercise clause of the first amendment³⁰⁹ circumscribed the broad language of the state law.³¹⁰ Ultimately, however, the court remanded the case to determine Ricky's religious beliefs,³¹¹ and reserved decision with respect to any possible parent-child conflict.³¹²

The court adopted a test by which to evaluate the state's interest when it conflicted with a parent's religious views as to the proper care for a child; the state must show "a substantial threat to society"³¹³ to outweigh protections provided to individuals under the first amendment.³¹⁴ The court carefully distinguished cases in which the child's life was in danger,³¹⁵ declining to express any view on the results of their balancing test in such situations.³¹⁶ The majority viewed with horror the ramifications of discarding the fatal-nonfatal distinction as in *Sampson*. The Pennsylvania Court feared that to permit wide judicial discretion to make decisions merely on the basis of whether the treatments were "required"³¹⁷

Pa. Stat. Ann. tit. 11, § 50-101 et seq. (Supp. 1973). See 448 Pa. at ____ nn.2 & 3, 292 A.2d at 388 nn.2 & 3.

308. 448 Pa. at ____, 292 A.2d at 388.

309. "Congress shall make no law respecting the establishment of religion. . . ." U.S. Const. amend. I.

310. See 448 Pa. at ____, 292 A.2d at 388-91.

311. *Id.* at ____, 292 A.2d at 392. This procedure was consistent with the majority's view of Justice Douglas' dissent in *Wisconsin v. Yoder*, 406 U.S. 205, 241 (1972) (see note 314 *infra*) and recent Pennsylvania extensions of the rights of minors in various contexts. See, e.g., *Commonwealth v. Moses*, 446 Pa. 350, 287 A.2d 131 (1971); *Falco v. Pados*, 444 Pa. 372, 282 A.2d 351 (1971); *In re Snellgrose*, 432 Pa. 158, 247 A.2d 596 (1968).

312. 448 Pa. at ____, 292 A.2d at 392. See *In re Green*, 452 Pa. 373, 307 A.2d 279 (1973), affirming trial court's finding after the evidentiary hearing on remand that Ricky did not want the surgery because of religious and medical reasons.

313. *Id.* at ____, 292 A.2d at 389, and alluding to *Sherbert v. Verner*, 374 U.S. 398, 403 (1963). See note 305 *supra*.

314. See *Wisconsin v. Yoder*, 406 U.S. 205, 233-34 (1972), where the Supreme Court held that the free exercise clause barred the application of a compulsory education statute to the members of the Amish sect. See Comment, 11 *Duquesne L. Rev.* 440, 446 (1973), which posited an alternative to the "substantial threat to society" requirement to justify judicial interference. The court should inquire: (1) Will the state be subjected to additional burdens by refusing to order the operation, and (2) Are the child's parents aware of all the consequences of not ordering the operation?

315. See 448 Pa. at ____, 292 A.2d at 390 and cases cited therein. In particular, the court distinguished *Jehovah's Witnesses in the State of Washington v. King County Hosp.*, 278 F. Supp. 488 (W.D. Wash. 1967), *aff'd per curiam*, 390 U.S. 598 (1968), on the ground that the prior case involved the application of a statute where children's lives were in imminent danger. But see the *Sampson* court's use of *King County Hosp.*, notes 297-99 *supra* and accompanying text. Cf. *Wisconsin v. Yoder*, 406 U.S. 205, 233-34 (1972), which relied upon *Application of President & Directors of Georgetown College*, 331 F.2d 1000 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964), which involved life-saving treatment for an adult. 448 Pa. at ____, 292 A.2d at 390.

316. 448 Pa. at ____, 292 A.2d at 392.

317. See *Sampson*, 65 Misc. 2d at 671, 317 N.Y.S.2d at 654.

would cause "endless problems" in interpreting and equitably applying the rule to later cases.³¹⁸

Justice Eagen wrote a vigorous dissent focusing on the majority's dichotomous analysis of the interests at stake, and found their opinion insufficiently solicitous of the health and well-being of Ricky Green.³¹⁹ Rejecting the majority's life or death emphasis as unsupported by the Pennsylvania statute³²⁰ or the case law, Eagen noted that the decisions in both *Wisconsin v. Yoder*³²¹ and *Prince v. Massachusetts*,³²² each relied upon by the majority, employed only the word "health."³²³ Justice Eagen's final disagreement with the majority centered on the infeasibility and impropriety of asking a dependent child to choose between the chance for a normal life and his parents' religious beliefs.³²⁴

While the logic of this dissent seems forceful and realistic, it fails to raise several additional available arguments. Eagen never directly confronted either the majority's central requirement of a "substantial threat to society" or their application of the standard.³²⁵ It could have been argued that just as the child labor law upheld over religious objections in *Prince*³²⁶ reflected a societal judgment that child labor in general was an evil to be avoided, child neglect statutes represent an analogous determination vis à vis parents' treatment of their children. Both types of statutes empower the state to act pursuant to its compelling interest of protecting the health and welfare of children.

Another available rebuttal to the majority's reasoning could have focused on their strained use of the *Yoder* decision.³²⁷ Not only did the court rely upon dictum, ignoring express qualifications where health was concerned, but it also inadequately explained the *Yoder* court's failure to consider the children's views on the issues at bar.³²⁸ The *Green* facts

318. 448 Pa. at ___, 292 A.2d at 392.

319. Id. at ___, 292 A.2d at 393.

320. See note 307 supra.

321. See note 314 supra.

322. 321 U.S. 158 (1944) (upheld child labor law over religious objections).

323. 448 Pa. at ___, 292 A.2d at 394-95.

324. Id. at ___, 292 A.2d at 395. See *Sampson*, 65 Misc. 2d at 672, 317 N.Y.S.2d at 655, relying on *Matter of Seiferth*, 309 N.Y. 80, 86-87, 127 N.E.2d 820, 823 (1955) (Fuld, J., dissenting). See Kleinfeld, *The Balance of Power Among Infants, their Parents and the State*, 4 Family L.Q. 320 (1970). "A great proportion of the decisions made by parents for children cannot meet with resistance because the child is too ignorant and unsophisticated to understand the ramifications of the decision and question it, or even to realize that legitimate alternatives were open and a decision was made." Id. at 424.

325. See 41 U. Cin. L. Rev. 961, 965-66 (1972).

326. See note 322 supra.

327. See 448 Pa. at ___, 292 A.2d at 390, and as pointed out in Justice Eagen's dissent, see notes 314, 321 & 323 supra and accompanying text.

328. See 448 Pa. at ___, 292 A.2d at 392. The *Green* court argued that it was the parents who were prosecuted for their religious beliefs in *Yoder*, whereas "it is the child rather than the parent in this appeal who is directly involved."

were analytically similar to those in *Yoder* since each case concerned parents motivated by religious beliefs who wanted to contradict expressed public policy in the treatment of their children. The *Yoder* result was understandable since long-term compulsory public education might well have had a significant impact on the religious beliefs of the Amish children. The likelihood that Ricky's medical care would have affected his religious beliefs was substantially smaller, however, since undergoing one surgical procedure does not usually result in changes in a person's views of society and religion. Therefore, such a rationale hardly supports his or his parents' deeper involvement in the decision-making process.

In striking contrast to both *Green* and *Sampson*, but more in line with the earlier cases involving parental objections to medical treatment for their children,³²⁹ is *Interest of Henry Green*,³³⁰ a decision concerning a six year-old boy who was suffering from sickle cell anemia, an incurable hereditary blood disease. The Milwaukee County Court, relying upon the mother's "reasonable" non-religious objections in lieu of her doctrinal views as a Jehovah's witness, refused to order highly recommended medical treatment. The court's analysis proceeded on two levels—who has the right to decide about the child's treatment, and under what limitations. The court held, *inter alia*, that parents' exercise of religious freedom was not superior to the interest of the state as *parens patriae* in protecting a child's welfare.³³¹ Nevertheless, the court held that parental discretion should control where there is doubt as to the "efficacy of the proposed medical procedures and great danger or risk of death to the child by the treatment proposed."³³² Although there was strong medical evidence attesting to the benefit of a blood transfusion, the court dismissed the neglect petition which had brought on the proceeding, since the mother's objections were logical, reasonable and made in good faith.³³³ *Henry Green* represents relatively early judicial recognition that, rather than

329. See, e.g., *Matter of Seiferth*, 309 N.Y. 80, 127 N.E.2d 820 (1955) (which relied not upon the father's beliefs, but rather upon the child's resistance to the proposed treatments because of his indoctrination); *In re Tuttendario*, 21 Pa. Dist. 561, 562 (Phila. County Ct. 1911), noted in 14 *Crime & Delinq.* 107, 112 n.12 (1968); *Matter of Hudson*, 13 Wash. 2d 673, 126 P.2d 765 (1942). See also *In re Frank*, 41 Wash. 2d 294, 248 P.2d 553 (1952).

330. 12 *Crime & Delinq.* 377 (Child. Div. Milwaukee County Ct. Mar. 18, 1966).

331. 12 *Crime & Delinq.* at 382. A degree of parental discretion, however, was found to exist as a result of the ninth amendment and the judicially-developing right to privacy as interpreted in *Griswold v. Connecticut*, 381 U.S. 479 (1965). *Id.*

332. 12 *Crime & Delinq.* at 384.

333. *Id.* at 384-85. The court premised its decision against the treatment on the possible risks involved in blood transfusions which would at most prolong Henry's life, the serious doubt as to the usefulness of the proposed medical procedures which were new and experimental, and the inaccuracy of medical advice in the past which had incorrectly indicated a dire need for such transfusions. *Id.* Cf. *Kaimowitz v. Michigan Dep't of Mental Health*, Civ. No. 73-19434-AW (Mich. Cir. Ct. July 10, 1973), noted in 42 *U.S.L.W.* 2063. See notes 105-54 *supra* and accompanying text.

blindly adhering to medical testimony in all circumstances, courts should afford some probative value to parents' views, even when those ideas are in conflict with the physician's opinion. The numerous medical judgments necessitated by the court's test, however, highlight once again the difficulties encountered in resolving "medico-legal" questions in patients' rights litigation.³³⁴

Though we lament the fact that Ricky Green will not receive spinal surgery, the court's conclusion to allow a mentally alert sixteen year-old to have significant input in making his own health care decision seems completely defensible.³³⁵ However, to the extent that the decision turns on *Ms. Greens'* first amendment rights, rather than Ricky's right to control his own body, the case's precedential value for minor's health rights is diminished. The *Sampson* decision, in contrast, permitting needed corrective surgery, achieves an admirable result for Kevin but unfortunately invokes the fear of a return to judicial paternalism reminiscent of the pre-*Gault* era.³³⁶ This implication, however, may be mitigated by the facts of Kevin's case. Although the court never explicitly analyzed Kevin Sampson's competence to understand the nature of the procedure and to make an informed choice, his undeniable inability to do either probably played a determinative part in the court's decision. In *Henry Green*, the issue of the patient's own informed consent never arose because the child involved was too young to participate in the decision-making; the court instead gracefully avoided the subjective determination of Henry's best interests and looked instead to the "reasonableness" of his mother's objections. *Henry Green* utilized a balancing test in which the court considered many pertinent factors similar to those in the abortion decision *Matter of P.J.*³³⁷

CONCLUSION

This overview of many of the recent cases involving patients' rights demonstrates that definitive conclusions are difficult at best. The primary impression, by way of a partial disclaimer, must be that there is an enormous tension among the many weighty interests presented in this area of

334. See *Kaimowitz*, Civ. No. 73-19434-AW (Mich. Cir. Ct. July 10, 1973). See also cases such as *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972), which confronts some of the difficulties encountered in trying to evaluate medical discretion. Finally, consider cases in which courts have issued, upon medical advice, emergency orders which have subsequently proved unnecessary. See, e.g., *Santos v. Goldstein*, 16 App. Div. 2d 755, 227 N.Y.S.2d 450, motion for leave to appeal dismissed, 12 N.Y.2d 672, 185 N.E.2d 904 (1962), 233 N.Y.S.2d 465 (1962); *In re Clark*, 21 Ohio Op. 2d 86, 185 N.E.2d 128, 90 Ohio L. Abs. 21 (C.P. 1962).

335. See final opinion of case after remand *In re Green*, 452 Pa. 373, 307 A.2d 279 (1973). See text accompanying note 311 *supra* and note 312 *supra*.

336. *In re Gault*, 387 U.S. 1 (1967).

337. 12 Cr. L. Rptr. 2549 (D.C. Super. Ct. Feb. 6, 1973). See notes 247-49 *supra* and accompanying text.

law: the intimate, personal rights of the patient, the schooled and concerned opinions of the physicians, the well-intentioned parental desire for their children's well-being, and the solicitude of the state for the health and welfare of its population. The decisions, practically uniform in their lack of articulate standards, reflect the enormity of the burden as well as the complexity of the determinations and, unfortunately, leave subsequent courts and commentators to inference. Some guidelines have, however, tentatively emerged. Judicial and legislative behavior have evidenced a trend toward the recognition of minors' capacity to consent to their own health care. This development is reflected not only in liberalized medical consent statutes but also in judicial solicitation of minors' views about the proposed treatment. As the questions become more complex, courts have begun to move away from deciding what is in the child's best interest and toward determining who shall make the decisions affecting a minor's life. In general, where the patient is mature and competent enough to understand the nature of the issues involved, the courts have increasingly deferred to his or her own wishes.

Nevertheless, looking to the future, one must make an ardent plea for more clearly explicated rationales in decisions involving patients' rights. In speculating, one might note that the title of a book written by a women's collective may prove to be an apt forecast of judicial determinations to come—*Our Bodies, Ourselves*.³³⁸

338. Boston Women's Health Book Collective, *Our Bodies, Ourselves* (1973).